# PART II

## POLICIES AND PROCEDURES
## for
## DURABLE MEDICAL EQUIPMENT SERVICES



**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

MEDICAL ASSISTANCE PLANS DIVISION

October 1, 2022

## Policy Revisions Record for 2022
## Part II Policies and Procedures Manual for Durable Medical Equipment Services

| REVISION DATE | SECTION | REVISION DESCRIPTION | REVISION TYPE<br>**A**=Added<br>**D**=Deleted<br>**M**=Modified | CITATION<br>(Revision required by Regulation, Legislation, etc.) |
|---|---|---|---|---|
| 01/01/2022 | 1111 | Purchase Limitations | **M** | |
| 01/01/2022 | 601.22 | Net Cost Defined | **M** | |
| 01/01/2022 | Appendix D | Net Cost Defined | **M** | |
| 01/01/2022 | Appendix F | Ventilator CMN | **M** | |
| 07/01/2022 | Appendix K | Updated the Contact Information | **M** | |
| 07/01/2022 | Appendix B | Updated Statement of Participation | **M** | |
| 07/01/2022 | 1104.1 | Added Clarification for Glucose Logs | **M** | |
| 10/01/2022 | 905. | Added Clarification for Non-Covered Items | **M** | |
| 10/01/2022 | 1112.9 | Supplemental Oxygen Therapy | **A** | |
| 10/01/2022 | 1112.11 | Disposable Oxygen Probes | **A** | |
| 10/01/2022 | 1114.3 | Customized Tracheostomy Tubes | **A** | |
| 10/01/2022 | 1109.1 | Enteral Supplies - B9998 | **M** | |
| 10/01/2022 | 1113.2 | Respiratory Suction Supplies - A7001 | **A** | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

# PREFACE

This manual contains basic information concerning the Durable Medical Services (DME) program and is intended for use in conjunction with the Part I Policy and Procedure Manual for Medicaid and PeachCare for Kids, which contains the Statement of Participation and encompasses general terms and conditions for receipt of reimbursement.

We urge providers and their administrative and billing staff to become familiar with the contents of this manual and the Part I manual, and to refer to them when questions arise regarding policies and procedures for the proper billing and coding guidelines for these services. Use of the manuals will assist in the elimination of misunderstandings concerning the coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and Department of Community Health (the Department), policy. When such amendments are made, they will be posted at www.mmis.georgia.gov, which shall constitute formal Notices to providers. The amended provisions will be effective on the date of the Notices or as specified by the Notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your participation and interest in Georgia's Medicaid/PeachCare program. Your service is greatly appreciated.

# TABLE OF CONTENTS


| | |
|---|---|
| **PREFACE** | Introduction |
| **QUARTERLY UPDATES** | Policy Revision Records |
| **CHAPTER 600** | CONDITIONS OF PARTICIPATION |
| **CHAPTER 700** | SPECIAL ELIGIBILITY CONDITIONS |
| **CHAPTER 800** | PRIOR APPROVAL GUIDELINES |
| Section 801 | General |
| Section 802 | Services That Require Prior Approval |
| Section 803 | Procedures for Obtaining Prior Approval |
| Section 804 | Provider's Review of an Approved Request |
| Section 805 | Billing for Prior Authorized Services |
| Section 806 | Equipment Rentals |
| **CHAPTER 900** | **SCOPE OF SERVICES** |
| Section 901 | General |
| Section 902 | Coverage Guidelines for Durable Medical Equipment |
| Section 903 | Face-to-Face (F2F) Encounter Requirements |
| Section 904 | Coverage for Medical Supplies |
| Section 905 | Non-Covered Services |
| Section 906 | Durable Medical Equipment Purchase (NU) Guidelines |
| Section 907 | Durable Medical Equipment Rental (RR) Guidelines |
| Section 908 | Maintenance, Repairs, and Replacements |
| Section 909 | Table of Repairs with Allowed Units of Service |
| Section 910 | Reasonable Useful Lifetime (RUL) for Durable Medical Equipment |
| Section 911 | Temporary Out-of-State Provider Limitations |
| Section 912 | Enrolled Out-of-State Provider Limitations |
| Section 913 | General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers |
| Section 914 | Commonly Used Acronyms |
| **CHAPTER 1000** | **BASIS FOR REIMBURSEMENT** |
| Section 1001 | Durable Medical Equipment Services (Reimbursement Methodology and Copay Information) |

| | |
|---|---|
| **CHAPTER 1100** | **MEDICAL POLICIES AND SPECIAL COVERAGE CONSIDERATIONS** |
| | **Augmentative and Alternative Communication Devices** |
| **Policy 1101** | |
| | General Provisions for Speech Generating Devices |
| | Definitions |
| | Non-Covered Items |
| | Prior Authorization |
| | Required Data |
| | Third Party Liability |
| | Trial Period |
| | Notice for Decision |
| 1101.1 | Mobile Devices with Qualifying Software Covered as a Speech Generating Device (SGD) for Alternative Augmentative Communication (AAC) Therapy |
| 1101.2 | Speech Aid |
| **Policy 1102** | **Complex/Custom Rehabilitative Equipment** |
| | Supplier Requirements for Complex Custom Rehab Equipment |
| | Physical or Occupational Therapist (PT/OT) Requirements |
| 1102.1 | Complex Custom Wheeled Mobility Devices<br>-Power Mobility Devices |
| 1102.2 | Other Assistive Custom/Complex Rehabilitative Equipment |
| 1102.2a | Specialty Walkers |
| 1102.2b | Shower/Bath Chairs and Other Rehab Toilet Aids |
| 1102.2c | Standing Frames/ Sit-to-Stand Systems |
| 1102.2d | Gait Trainers |
| 1102.2e | Patient Lifts |
| **Policy 1103** | **Manual Wheelchairs and Other Considerations** |
| **Policy 1104** | **Diabetes Management** |
| 1104.1 | Continuous Glucose Monitor |
| 1104.2 | Blood Glucose Monitor and Supplies |
| **Policy 1105** | **Home Phototherapy** |
| **Policy 1106** | **Hospital Beds and Accessories** |
| 1106.1 | Enclosed Pediatric Beds or Canopy |

| | |
|---|---|
| **Policy 1107** | **Inexpensive/ Routinely Purchased Equipment** |
| 1107.1 | Commode Chairs/ Raised Toilet Seat |
| 1107.2 | Canes/Crutches |
| 1107.3 | Walkers |
| **Policy 1108** | **Infusion Therapy** |
| 1108.1 | External Infusion Pumps |
| 1108.2 | Insulin Infusion Pumps |
| 1108.3 | Parenteral Infusion Pumps |
| 1108.4 | iPort (Subcutaneous injection port) |
| **Policy 1109** | **Nutritional Therapy or Supplementation Services** |
| 1109.1 | Enteral Nutrition |
| 1109.2 | Oral Medical Foods |
| 1109.3 | Electric Breast Pumps |
| **Policy 1110** | **Osteogenesis Stimulator** |
| **Policy 1111** | **Pressure Reducing Support Surfaces (PRSS)** |
| 1111.1 | GROUP 1 Pressure Reducing Support Surfaces |
| 1111.2 | GROUP 2 Pressure Reducing Support Surfaces |
| **Policy 1112** | **Respiratory Services** |
| | Complex Respiratory Supplier Provisions<br>Non-Complex Respiratory Supplier Provisions |
| 1112.1 | Apnea Monitors (Infant) |
| 1112.2 | Automatic External Defibrillators |
| 1112.3 | Continuous Positive Pressure Airway Devices (CPAP/BIPAP) and Accessories |
| 1112.4 | Nebulizers and Accessories |
| 1112.5 | Altera Nebulizer (Replacement Only) |
| 1112.6 | High Frequency Chest Wall Oscillation Devices |
| 1112.7 | Intrapulmonary Percussive Ventilation (IPV) System |
| 1112.8 | Mechanical In-Exsufflation Devices (Cough Stimulating Device) |
| 1112.9 | Oxygen and Oxygen Related Equipment |
| 1112.10 | Ventilators |
| 1112.11 | Pulse Oximeters |
| **Policy 1113** | **Suction Pumps and Supplies / Wound Care** |

1113.1 Negative Pressure Wound Therapy Devices
1113.2 Respiratory Suction Pumps

**Policy 1114 Supplies**

1114.1 Ostomy Supplies
1114.2 Surgical Dressings
1114.3 Tracheostomy Supplies
1114.4 Wound Care Supplies

**Policy 1115 Transcutaneous Electrical Nerve Stimulators (TENS)**

**Policy 1116 Urological Supplies**

| APPENDIX | DESCRIPTION |
|---|---|
| **A** | SAMPLE MEDICAID ID CARD |
| **B** | STATEMENT OF PARTICIPATION |
| **C** | INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION REQUEST FORM AND CMS 1500 (version 02/12) CLAIM FORM (FORMS ATTACHED) |
| **D** | DURABLE MEDICAL EQUIPMENT CODES THAT REQUIRE MANUAL PRICING (MANUFACTURER'S QUOTE INVOICE REQUIRED) |
| **E** | LIST OF COVERED WHEELCHAIR COMPONENTS OR ACCESSORIES NOT OTHERWISE SPECIFIED (K0108) THAT REQUIRE MANUAL PRICING (MANUFACTURER'S QUOTE INVOICE REQUIRED) |
| **F** | CERTIFICATE OF MEDICAL NECESSITY FORMS<br>❖ Apnea/Bradycardia Monitor<br>❖ Group 1 Pressure Reducing Support Surface<br>❖ Continuous Positive Pressure Airway Device (CPAP)<br>❖ Intermittent Assist Device (BIPAP)<br>❖ Transcutaneous Electrical Nerve Stimulators (TENS)<br>❖ Enteral Nutrition (*Must be under 21 years of age*)<br>❖ Hospital Bed<br>❖ Insulin Infusion Pump (Attach manufacturer's Invoice)<br>❖ Continuous Glucose Monitor (*Must be under 21 years of age*)<br>❖ Oxygen Equipment<br>❖ Patient Lift<br>❖ Respiratory Suction Pump<br>❖ Full Volume Ventilator<br>❖ Custom Durable Medical Equipment (Requires PT/OT Evaluation)<br>❖ Standard Wheelchair (Requires PT/OT Evaluation if under 21years of age)<br>❖ Power Wheelchair (Requires PT/OT Evaluation)<br>❖ Scooter (POV) (Requires PT/OT Evaluation)<br>❖ Mobile Device Used as A Speech Generating Device with AAC Application or Software (Requires SLP Evaluation)<br>❖ External Infusion Pump and Supplies |
| **F.1** | FACE-TO-FACE EVALAUATION<br>❖ Face-To-Face Encounter Certification |
| **G** | DOCUMENTATION REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT |
| **H** | GEORGIA FAMILIES |
| **I** | GEORGIA 360° |

| | |
|---|---|
| **J** | GENERAL CLAIMS SUBMISSION POLICY FOR ORDERING, PRESCRIBING, REFERRING (OPR) PROVIDERS |
| **K** | GEORGIA HEALTH PARTNERSHIP (GHP) |
| **L** | (PAGE INTENTIONALLY LEFT BLANK) |
| **M** | COMMONLY ASKED QUESTIONS (Q&A) |
| **N** | (PAGE INTENTIONALLY LEFT BLANK) |
| **O** | COMMON MODIFIERS |

# CHAPTER 600

## DME SUPPLIER STANDARDS FOR PARTICIPATION IN THE GEORGIA MEDICAID PROGRAM

601. **In addition to all conditions of participation in the Medical Assistance Program as outlined in the Part 1 Policies and Procedures for Medicaid and PeachCare for Kids, Section 106, providers of Durable Medical Equipment must also be compliant with all standards outlined in Chapter 600 of the Part II Policies and Procedures for Durable Medical Equipment Services.**

601.1 A supplier must comply with all applicable Federal and State licensure and regulatory requirements and agree to adhere to all policies and procedures of the Durable Medical Equipment Program as herein stated and hereafter amended.

601.2 A supplier must provide the Department with a valid business license. A business license is considered valid if it is in accordance with the services to be provided. If the local county business codes do not require a business license, then the provider must submit evidence to that effect to Provider Enrollment.

601.3 A supplier must submit proof of comprehensive liability insurance in the amount of no less than $300,000.00 that covers both the supplier's place of business and all customers and employees of the provider. If the supplier manufacturers its own items, this insurance must also cover product liability and completed operations. (Rev. 01/14)

601.4 A supplier must submit proof of accreditation for each location enrolled in the Durable Medical Equipment Program. All DME suppliers must be fully accredited by a CMS approved accreditation agency by 09/30/2009 in order to receive and retain a provider billing number from Georgia Medicaid. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services. Suppliers must remain accredited for the duration of enrollment as a Georgia Medicaid provider. (Rev. 07/14)

**CMS Excludes a Pharmacy from accreditation if it meets <u>ALL</u> the following criteria:**

- The total billings by the pharmacy for DMEPOS are less than 5% of total pharmacy sales;
- The pharmacy has been enrolled as a provider of durable medical equipment and has been issued a provider number for at least 5 years;

- No final adverse action has been imposed on the pharmacy in the past 5 years;
- The pharmacy submits attestation, as determined by CMS, that the pharmacy meets the first three criteria;
- The pharmacy agrees to submit materials as requested during the course of an audit conducted on a random sample of pharmacies selected annually.

**CMS Approved Accreditation Organizations for DMEPOS Providers Include:**

The Joint Commission (TJC)
Commission on Accreditation of Rehab Facilities (CARF)
Community Health Accreditation Program (CHAP)
Healthcare Quality Association on Accreditation (HQAA)
Accreditation Commission for Health Care (ACHC)
The American Board for Certification in Orthotics/Prosthetics, Inc. (ABC)
Board of Certification/Accreditation (BOC)
The Compliance Team, Inc.
National Association of Boards of Pharmacy (NABP)
The National Board of Accreditation for Orthotic Supplies (NBAOS)

DME suppliers are responsible for selecting the appropriate accreditation organization (AO) for their business.

**Complex Custom Rehab Providers** must be accredited through one of the following approved accreditation organizations for the service of Complex Custom Assistive Technology: The Joint Commission (TJC), Commission on Accreditation of Rehab Facilities (CARF), Community Health Accreditation Program (CHAP), Healthcare Quality Association on Accreditation (HQAA), Accreditation Commission for Health Care (ACHC) or The Compliance Team

**Complex Respiratory Providers** must be accredited through one of the following approved accreditation organizations: The Joint Commission (TJC), Commission on Accreditation of Rehab Facilities (CARF), Community Health Accreditation Program (CHAP), Healthcare Quality Association on Accreditation (HQAA), Accreditation Commission for Health Care (ACHC) or The Compliance Team

601.5 A supplier must notify their accreditation agency when a new DME location is opened and enrolled in Georgia Medicaid to ensure they are accredited or in the process of becoming accredited. (Rev. 0714)

601.6 All physical locations whether owned or subcontracted, must meet the Georgia Medicaid Provider Statement of Participation requirements and be SEPARATELY accredited in order to receive a provider ID to be reimbursed by Georgia Medicaid. Any accreditation exceptions made by accrediting organizations where suppliers have more than one location in the same state must be submitted to provider enrollment for verification through the accrediting agency. (Rev. 0714)

601.7 A supplier must have an authorized individual whose signature is binding sign the enrollment application for billing privileges. (Rev. 07/14)

601.8 A supplier must notify the Provider Enrollment Unit in writing of any change in enrollment status, including changes to the address of the physical location or phone number.

601.9 A supplier must submit all information requested by provider enrollment including, but not limited to, the types of services provided with a list of equipment/supplies and the associated HCPCS codes, and the location(s) to be serviced.

601.10 A supplier must be open to the public for business during posted hours of operation (a minimum of thirty (30) hours per week). Exception: Occupational or Physical Therapists and DME providers who are also enrolled in COS 330 who work with custom orthotics and prosthetics. (Rev. 07/14)

601.11 An Out-Of-State provider that is enrolled in Medicare may enroll with Georgia Medicaid for the purpose of reimbursement of crossover claims for Georgia residents. **See Section 910** for Out-Of-State Providers and Service Limitations for services provided to Georgia Medicaid members in an Emergency or when prior approval is obtained from the Department before the service is provided.

601.12 A supplier must have a physical location on an appropriate site that is within the state of Georgia or within fifty (50) miles of the state border and be in an area in which Georgia residents customarily obtain medical services. The location must have a visible sign with hours of operation posted. The location must be opened to the public, handicapped accessible, and staffed during normal business hours (a minimum of 30 hours per week). The provider must have a physical location that has sufficient storage space for medical records and for the equipment and supplies which they provide. (Rev. 07/14)

601.13 A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of a mobile device, answering machine, or answering service during normal business hours is prohibited. (Rev. 07/14)

601.14 A supplier must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking or hold accreditation. (Rev. 07/14)

601.15 A supplier must disclose **any person** having ownership, financial or control interest in the business. (Rev. 07/14)

601.16 A supplier must permit Georgia Medicaid or its agents to conduct on-site inspections to ascertain the supplier's compliance with supplier standards or to investigate allegations of fraud, waste, and abuse. (Rev. 07/14)

601.17 A supplier may not directly solicit Medicaid beneficiaries. This excludes (1) members that have given permission for the contact in writing (2) members who previously received a covered item for which the supplier is making the contact (3) telephone contact to a member in regard to an item other than the covered item that was previously furnished if the member has received a covered item from the supplier in the previous fifteen (15) months. (Rev. 07/14)

601.18 Suppliers are subject to the "Anti-Kickback Statute" which prohibits the exchange (or offer to exchange), anything of value, in an effort to induce (reward) the referral of Federal/State healthcare program business (reimbursement). (Rev. 07/14)

601.19 Suppliers must maintain copies of current licenses or certifications of the healthcare professionals involved in and qualified to perform services related to complex respiratory services (apnea monitors, volume ventilators, therapeutic ventilators, respiratory assist devices [CPAP/BIPAP]), ALL custom or complex rehab equipment, home phototherapy, or any other equipment requiring licensure or certification as specified, per Georgia Medicaid policy.

601.20 Effective on or after January 1, 2006, Custom/Complex Rehab Providers must have employees who are registrants of NRRTS (National Registry of Rehab Suppliers) **AND** are ATP (Assistive Technology Professional) certified through RESNA (Rehabilitation, Engineering and Assistive Technology Society of North America). Effective 07/01/2013, providers must submit a copy of the valid certification when requesting a prior authorization. (Rev. 07/14)

Custom rehab suppliers must have a repair and service department at their physical location with a qualifying repair technician who is available during normal posted business hours (open to the public a minimum of 30 hours per week).

601.21 A supplier must fill orders and fabricate and fit items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide upon request copies of contracts or other documentation showing compliance with this standard. A supplier may not contract with any entity that is currently excluded from Medicare or any State Medicaid Program, or from any other Federal Government Executive Branch procurement or non-procurement program or activity. A subcontractor that only performs these services does not need to be accredited. (Rev. 07/14)

601.22 Suppliers must provide binding quotes containing the provider's net cost, the primary discount, and MSRP (secondary and tertiary discounts are not required) attached to requests for prior authorization for all items requiring manual pricing (Refer to Appendix D/E for manually priced items) Note: Net cost is defined as the provider's total cost after all discounts have been applied. (Rev. 01/22)

601.23 Suppliers must agree to provide quality items of service and maintain/repair items provided. If complaints are filed with the Department, the Department may perform an investigation and/or review of the provider. If the results of the investigation and/or review indicate noncompliance with Department policies, the Department may perform an additional investigation and/or review to establish continuing competency of the provider. If the results of this investigation and/or review are not in compliance with Department policies, adverse actions as outlined in Part I, Chapter 400 apply.

601.24 A supplier must accept returns of substandard (less than full quantity) and/or inappropriate items (items not meeting quality standards, not properly fitted based on the height and weight of the patient, or not reasonable and necessary for the patient for which it was provided) that were not appropriate for the member at the time the item was fitted, rented, or purchased. Providers must submit a refund to Georgia Medicaid or replace the device promptly when these situations are identified. Constituent complaints resulting in replacement of items by another provider for correct item (same or similar services) will result in recoupment of the original item. (Rev. 07/14)

601.25 Suppliers must stand behind a two (2) year warranty of the major components of custom wheelchairs.

601.26 A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicaid covered items under warranty.

601.27 A supplier must maintain, repair, or replace at no charge items that are being rented (capped or indefinite). These services are considered to be included in the rental fee. (Rev. 01/14)

601.28 A supplier must bill the Department their usual and customary fee (usual and customary is defined as the lowest of: the lowest price charged to other third party payers including HMO's or the lowest price regularly and routinely offered to any segment of the general public, but excluding charitable donations) for services provided for which a fee schedule amount exists, unless the item is manually priced on the prior authorization, per DCH Policy. (See-Appendix D/E). For manually priced items, the amount submitted must be the amount that has been approved for reimbursement on the prior authorization. (Rev. 01/14)

601.29 **A supplier must accept the Department's payment as payment in full for covered services to a patient accepted as a Medicaid member.** A patient will be deemed accepted as a Medicaid member if (s)he is eligible as a member for those services, the provider represents or demonstrates to the patient that (s)he will treat the patient as a Medicaid member, or the provider bills the Department for covered services. Note: This does not prohibit the provider from receiving reimbursement from liable third parties in accordance with Department policies. See Part 1, Section 303.

601.30 A supplier must accept responsibility for providing the appropriate equipment/supplies, setting up and assembling the equipment in the home, and training the member on the appropriate usage or utilization of the equipment and/or supplies according to the manufacturer's instructions, and the Department's policies and procedures. Suppliers are responsible for follow-ups, additional training, compliance monitoring, and maintenance and repairs of equipment and supplies they provide.

601.31 A supplier is responsible for the delivery of all items supplied and must instruct members on the use of Medicaid covered items and must maintain proof of delivery and beneficiary instructions in the patient's record. (Rev. 07/14)

601.32 A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of these contacts. A complaint resolution protocol must be established to address complaints related to these standards. These records must contain the members name, address, and phone number, health insurance claim number (HICN), a summary of the complaint and any actions taken to resolve the issue. The complaint and resolution record must be maintained at the physical location and must be made available to the Department upon request. (Rev. 01/14)

601.33 A supplier must maintain documentation from the Ordering or Prescribing provider for all services billed to Georgia Medicaid for reimbursement. The Ordering or Prescribing provider's information (NPI) must be submitted on all claims submitted to Georgia Medicaid on or after June 1, 2014. (Rev. 07/14)

601.34 Suppliers are prohibited from filling out initial clinical evaluation information that is outside of their scope of practice, including but not limited to: Physical or Occupational Therapy Evaluations, Clinical Assessments on a Certificate Of Medical Necessity, Prescriptions, or any other document for which they do not hold licensure to complete. DME provider's may only complete or assist in the completion of equipment-based information that requires collaboration between the clinical professional and supplier of equipment. (Rev. 07/14)

601.35 Suppliers must make home visits as necessary and regularly follow-up on all frequently serviced devices and/or life-supporting equipment for maintenance and member compliance. These items include devices such as apnea monitors, volume ventilators, therapeutic ventilators, respiratory assist devices (CPAP/BIPAP), oxygen systems, and insulin or parenteral infusion pumps. Life sustaining devices as defined as complex respiratory equipment must be supported by a credentialed respiratory therapist. (Rev. 07/16)

601.36 Suppliers must obtain oxygen from a state-licensed oxygen supplier. (Rev. 07/14)

601.37 Suppliers must submit procedure code(s) that most accurately describe the item or service actually provided when requesting a prior authorization or submitting a claim.

601.38 Suppliers are prohibited from submitting claims for items or services that have not been delivered prior to the claim submission. The record of delivery (delivery ticket) must be kept on file and must provide verification that the item billed was delivered on or before the date the claim was submitted. (Rev. 07/14)

601.39 Delivery tickets for all items must be kept on file for a minimum of six (6) years and must be signed by the patient or a representative of the patient at the patient's community home. For mail order only items, a printed confirmation of delivery that contains a tracking number and the patients name, and demographic information must be present in the patient chart with a packing order describing the items delivered. A record of logged contact is required for mail order refills supporting member contact prior to shipping. (Rev. 07/15)

601.40 Suppliers are prohibited from denying services to any eligible Medicaid member based on the inability to pay a copayment, which includes the collection of any unpaid copayments on a later date or time. (Rev. 10/20)

601.41 Suppliers must maintain a complete and accurate patient record in the state of Georgia in accordance with the Conditions of Participation in Part I, Section 106 Subsection R for no less than six (5) years from the date of service of the most recent claim submitted to Georgia Medicaid for all patients. (Rev. 07/15)

601.42 Suppliers must comply with requests for documentation from the Department for any item for which they have attested during the prior authorization process (example: face to face evaluation). (Rev. 07/14)

601.43 Suppliers must have on file an invoice which specifies each applicable HCPCS code(s) correlating to a binding quote for any custom, complex, or manually priced item for which they submitted for and received reimbursement from the Department. This documentation must validate that the item provided is exactly the same item that was reimbursed as evident by the invoice number, MSRP and Net pricing, patient information (customer ID or Name), manufacturer, and serial numbers if applicable. The MSRP, primary discount and resulting net cost, (if applicable), and manufacturer's product numbers must align with the quote that was submitted for prior approval and reimbursement. Any discounts beyond the primary discount; including but not limited to secondary, tertiary, or other are considered to be proprietary business information of the supplier and are not required to be submitted to the Department. (Rev. 01/21)

601.44 The referring physician may not enroll as the DME provider, in accordance with Section 1877 of the Social Security Act (42 U.S.C. 1395nn).

## PART II - CHAPTER 700
## SPECIAL ELIGIBILITY CONDITIONS

In addition to any eligibility conditions listed in Part I, Policies and Procedures Services Manual Applicable to Medicaid Providers, Section 113, members seeking services under this Program must be referred by a physician, have a prescription signed by the physician and must not be institutionalized.

# CHAPTER 800
# PRIOR APPROVAL GUIDELINES

## 801. General (Rev.10/13)

As a condition of reimbursement, the Department requires that certain services be approved prior to the time they are rendered. Prior approval from the Department pertains to medical necessity only, and not appropriateness of service. It does not guarantee payment, member eligibility or payment of submitted charges. Correct Coding Initiative (NCCI/MUE) edits will deny items billed in excess of what CMS allows or items that are not appropriately reported together (unbundled).

801.1 Healthcare Common Procedural Coding System (HCPCS) Coding

Georgia Medicaid requires the submission of nationally recognized HCPCS codes and applicable standards in order to be reimbursed for approved DME services. The HCPCS coding system for DME includes the following levels of procedure codes:

a) Level II Alphanumeric codes for covered Medicare and Medicaid Services. The items are contained within the A, B, E, K, L, Q, and S codes.
b) Level III Codes created by CMS or its intermediaries for services for which no Level II codes have been established.

The Department utilizes unique HCPCS codes to further “safeguard against unnecessary or inappropriate us of Medicaid services and against excess payments”, as outlined in the Code of Federal Regulations, 42CFR456.3. For a list of HCPCS codes representing services that are reimbursed by Georgia Medicaid, refer to the Schedule of Maximum Allowable Payments (fee schedule codes) or Appendix D/E in the Part II manual (manually priced codes).

The Department does not recognize miscellaneous, unlisted, unspecified, not otherwise specified/classified (NOS/NOC) HCPCS codes; except for certain wheelchair accessory services not otherwise specified (K0108), until such time a unique code is assigned by CMS, refer to Appendix E of the part II manual.

## 802. Services That Require Prior Approval (Rev. 04/14)

802.1 Medical Supplies exceeding the maximum allowed units for the billing period

802.2 Medical equipment purchases in excess of $200.00

802.3 All Durable Medical Equipment Rentals (RR)

802.4 All submissions for reimbursement of labor (K0739 U1)

802.5 All submissions for reimbursement of miscellaneous repair items (K0739 U2)

802.6 All repairs exceeding a combined total of $200.00

802.7 Speech Generating Devices (Chapter 1100)

802.8 All items requiring manual pricing (Appendix D/E)

802.9 All items with prior authorization requirements on the SMAP

## 803. Procedures for Obtaining Prior Approval

803.1 Prior Authorization Request Forms

Providers must submit requests for prior approval via the web portal at www.mmis.georgia.gov, utilizing the appropriate prior authorization request form (DMA 610) with all supporting documentation uploaded via the web portal and attached to the request. Certificate of Medical Necessity (CMN) attachments for PA requests sent via the web portal will be requested by the review staff if it is not attached by the provider. If required information is not submitted, the case is considered incomplete and will be denied for missing information. (Rev. 01/09, 04/13)

**All initial requests for prior approvals are reviewed by the Department's Medical Review Agent, Alliant Health Solutions.** Review Coordinators trained in utilization review and URAC standards will evaluate the PA requests in accordance with the DCH DME Prior Approval Medical Review Process Guidelines.

Prior approval request forms must be submitted prior to placement of equipment with members. The PA/UM Department will evaluate the medical necessity for the purchase, rental, replacement, or repair of the equipment and/or supply and render a decision within 30 calendar days of the receipt of a completed case. An attending medical physician's prescription and certificate of medical necessity (CMN) must always accompany this form, or it will be denied. The physician must sign and date the prescription. Signature stamps or dates are not acceptable. Providers ***must not*** alter the signed CMN. Providers must store the original CMN and/or prescription on file. (Rev. 01/13)

Durable medical equipment requests must include the manufacturer's name and model number on the PA form. **The PA may be denied if the manufacturer's name and model number are not on the request.** This information will be listed in Item 19 (Statement of Services) on the CMS 1500

claim form for specific durable medical equipment. All requested items on the CMN must be listed in field 19 of the PA (one item per line). **Request forms received beyond ninety (90) days from the requested date of service cannot be retrospectively approved.** (Rev. 01/09)

Instructions for completing the prior authorization request form (DMA-610) are provided in Appendix C. Cases that are considered incomplete will be returned to the provider with a written notification, explaining what is missing. Providers will also have the option to submit the missing information within 30 business days of the date the notification was issued. Untimely cases will be denied. The requestor will be notified, in writing, of the option to appeal a denied case within 30 calendar days of the denial. Providers will receive notification of completed cases within 10 business days of receipt. Notification letters will be sent to both the provider and the member. Decisions may reflect an approval or denial of DME devices and supplies. Any adverse decisions may be appealed per DCH Policy, Part I, Chapter 503.

## 803.2 Prior Approval Requests

Prior approval can only be obtained through the web at www.mmis.georgia.gov.

Questions regarding covered services and prior approvals should be directed to the Automated Inquiry Unit at 1-800-766-4456. Once the inquirer has reached the inquiry unit, the caller will be prompted to listen to the available options and make selections based on the nature of the inquiry. (Rev. 01/09)

Effective December 1, 2014, only electronic submissions will be accepted.

## 803.3 Prior Approval Procedure (Rev. 04/13, 10/13, 01/21)

Providers must submit all prior authorizations electronically with all supporting documentation attached in order to expedite the prior approval process.

1. The provider must submit all requests for prior approval via the web portal.
2. The review coordinator screens and reviews all requests for prior approval for completeness, timeliness, and clarity, per DCH policy for DME (see DCH Medical Review Procedures). Each request for the purchase or rental of durable medical equipment, accessories, or supplies requiring attachments shall include the following information:

    a) A prescription and/or certificate of medical necessity (CMN), which includes the HCPCS code, dated fewer than 90 days prior to the date of service on the request;

b) A DME evaluation prepared by a Georgia licensed professional in the healing arts if required (occupational therapist, physical therapist, speech language pathologist, etc.), giving a comprehensive clinical assessment including the history, current and projected capabilities, and limitations as it pertains to the equipment being requested;

c) A complete description of the medical equipment and/or supplies requested including the model number, manufacturer's name and address, and the length of need for the items requested. If the length of need for equipment exceeds 10 months, then providers may request the purchase of the equipment where policy permits;

d) The member's medical diagnosis or condition requiring the use of the equipment, accessories, attachments and/or supplies;

e) The member's specific physical limitations;

f) The physician's handwritten or electronic signature and the date the physician signs the order (prescription and/or certificate of medical necessity). Signature stamps are **not** accepted.

g) Results of any previous trial periods of the requested equipment.

h) For manually priced items, the provider must submit a quote invoice containing:

- MSRP
- Primary Discount
- Net Cost
- Applicable HCPCS code(s)

There are no exceptions. Any alterations or missing information will result in a denial of the request for prior approval. Items will be priced based on DCH policy for the actual item being requested.

3. The review coordinator and the DCH Program Specialist must discuss requests for DME exceptions to determine appropriate disposition (see DME Exceptions Procedure).

4. Incomplete cases will be denied for missing information and returned to the provider with a written notification of the missing elements, and the option to submit the missing information within thirty (30) days through the reconsideration process. Untimely cases are denied, and the requestor will be notified of the option to appeal within thirty (30) days.

5. Complete cases will be reviewed based on evidence of medical necessity for cases that meet coverage criteria according to Inter-Qual or DCH approved policy criteria. More complex cases may be sent out for peer review before an approval or denial decision is made. DME Services may be approved for rental or purchase of the item requested.

6. Requests for attachments, replacements, or repairs should include copies of original warrantees and may be approved or denied based on policy guidelines. Repairs exceeding a combined total of $200.00 require PA, and repairs exceeding an annual total of $400.00 within a calendar year require a PA regardless of the total requested in excess of the annual maximum allowance. An explanation of benefits (EOB) for the repair history during the previous twelve (12) months must be submitted with the PA request. Multiple requests for repairs to the same equipment from same or different providers will result in the denial of requests. (Rev. 01/09)

7. Forms which may assist the provider in obtaining prior authorization for apnea/bradycardia monitors, continuous glucose monitors, continuous positive airway pressure devices, intermittent assist devices, enteral nutrition, hospital beds, insulin infusion pumps, nebulizers, oxygen equipment, patient lifts, speech generating devices, suction pumps, volume ventilators, and wheelchairs (custom, standard, power, and scooter) have been included in Appendix F. The provider ***must*** use the forms that are located in Appendix F, as these forms indicate all the required information that is vital in the expeditious review and processing of your requests. The information requested on these forms assists the reviewer in determining medical necessity for the equipment requested. Appendix G also provides guidance on requesting for these devices as well. If a prior approval is not required, the forms may be used as prescriptions or detailed written orders to be kept on file by the provider. (Rev. 07/18)

**The Department reserves the right to request additional documentation supporting the medical necessity and appropriateness of the equipment from other medical or non-medical professionals involved in the patient's**

**care (e.g., physical therapist, home health nurse, school nurse, teachers, manufacturer's invoice, or cost price to the provider etc., if applicable).**

**The prior approval (PA) analyst may request any reasonable and necessary information to help assess the medical necessity for the PA process.**

## 804. Provider's Review of an Approved Request

Providers should carefully review the request for services that have been approved by the Department. The Department must be notified in writing or by phone, of a provider's intent not to supply the equipment after it has been approved to avoid a delay in the member receiving the equipment through another provider. Providers must withdraw a prior authorization if there is any change that results in the provider not issuing the approved DME services so that the Department may assist the member in obtaining the services elsewhere.

The equipment provided to a member must be the equipment approved by the Department as described to be medically necessary on the prior authorization request form (based on the ordering physician's prescription) for the Department's allowed amount. The department does not purchase used equipment except in cases where the equipment was new prior to rental to the same member. (Rev. 04/13)

All modifications to base equipment must be supported by the prescribing medical physician's detailed written order. Should this information not be present, requests will be adjusted to basic items only.

Claims submitted to Georgia Medicaid for reimbursement must be submitted exactly as approved on the prior authorization. For items that are submitted for manual pricing the approved quantity and approved amount must be submitted as approved. Anything submitted in excess of what is approved will be recouped by Georgia Medicaid and referred to Program Integrity if the occurrence is identified as a standard of billing or trend.

### 804.1 Transfer of Service to Another Provider

When a member or physician decides to change providers, there is specific documentation required before the Department can withdraw the existing prior approval and reissue an approval for a new prior approval.

The provider who initially submitted a prior authorization must:

- Withdraw PA with a rationale explaining that the member has selected a new provider and the equipment is being picked up.
- Pick up the equipment and have the pick-up ticket on file

The new provider should submit a copy of the first provider's pickup ticket with the request for the new prior authorization. The new request is treated as such and will require the following: a new order, up to date documentation, and any other policy requirement for an initial request for the item.

804.2 Requests for an Extension on the Date of Service

If a provider is unable to supply the requested equipment for which a prior approval has been granted, within the authorized dates of service, and needs an extension the provider must:

For an extension for a service that does not have a break in service greater than 60 days:

1. Request an extension of the existing PA with a detailed rationale supporting the break in service via the reconsideration or change request web link.

For an extension that includes a break in service greater than 60 days all requirements for a new PA must be met:

2. Submit a new initial prior authorization request (DMA-610)
3. Submit a new CMN signed and dated by the physician

## 805. Billing for Prior Authorized Services

805.1 Billing Guidelines

The authorization number in the upper right-hand corner of the prior authorization request form (DMA-610) must be entered in box 23 on the claim form for the claim to be reimbursed.

The ICD-9-CM (on or before 09/30/2015) or ICD-10-CM (on or after 10/01/2015) (International Classification of Diseases- Clinical Modification) codes entered in box 17 of the DMA-610 must also be entered in box 21 and box 24e on the claim form. (Rev. 04/14)

The serial number of all purchased wheelchairs, lifts, fracture frames for complete traction, and the foot spring serial number of hospital beds must be entered on the claim with the appropriate purchase modifier. For equipment rentals (RR), enter the serial number on the claim for the tenth (10) month when

the equipment is considered to be purchased by the Department. Claims submitted without these serial numbers will be rejected by the system. For both purchases and rentals enter the **VP** qualifier followed by the serial number. There is no space between the qualifier and serial number (example: VPXXXXXX). (Rev. 04/13)

The date of delivery must be within the approved dates in Box 14 of the DMA-610. The date of service on the claim should be the date on the signed delivery ticket for in-person deliveries or the shipping date for mail order deliveries. **Do not bill the department prior to the delivery or shipping date of the item to be reimbursed.**

Items that require Prior Approval must be reported on the same claim as the items that do not require prior approval if they are provided for the base piece of equipment.

**The billed amount must not exceed the amount approved on the prior authorization. Any amount billed in excess of the amount approved on the prior authorization will be recouped if paid for manually priced items. Items that are paid based on standard SMAP rates will not have an approved amount listed on the prior authorization.**

805.2 Retroactive Eligibility

As outlined in Part I, Section 201.3, claims must be received by the Department within six (6) months from the month that retroactive eligibility is determined to be effective. For services requiring prior approval (PA), the Certification of Retroactive Eligibility (Form 964) or other official forms issued by the county Department of Family and Children's Services (DFCS) must be attached to the PA and must be received within sixty (60) days of the effective date the Department enters the retroactive eligibility data into the Georgia Medicaid Management Information System (GAMMS). It is the responsibility of the provider to verify member eligibility prior to rendering services.

805.3 Third Party Liability

Since the Department of Medical Assistance (Medicaid) is the payer of last resort, "Retroactive" authorizations may be granted for Medicaid members who have a primary insurance **only** if the primary insurer has reimbursed for a portion of the price of the equipment previously or if the item submitted is considered to be payable by Medicaid when it is noncovered by the primary payer, is covered by Georgia Medicaid, and the item is considered to be medically necessary. When submitting a prior authorization request for possible reimbursement of the balance when another insurance has reimbursed or the

allowed amount for items that are covered by Medicaid when the primary pays a zero-dollar amount, submit the prior authorization request form with explanation of medical benefits (EOB) attached as if the full amount (retail price), was being requested from the Department. The authorization request must be received within sixty (60) days of the date on the primary payer's EOB.

If the primary insurance company paid an amount that meets or exceeds the maximum amount allowed by the Department, additional reimbursement will **not** be made (typically paid at a $0.00 amount).

805.4 Medicare/Medicaid Coverage Guidelines (Rev, 04/13, 04/16)

If the member has Part B (or D for coverage for A4223 with the use of a Part D drug without a pump) and is covered by Medicare and Medicaid, then Medicare policy determines the medical necessity of the durable medical equipment or medical supplies as they are the primary payer. Cigna Government Services, Jurisdiction C, is the Medicare Administrative Contractor for the state of Georgia. Please refer to: http://www.cgsmedicare.com/jc/index.html for Local Coverage Determinations and Fee Schedules for DMEPOS items or call 1 (866) 270-4909 for provider related inquiries.

The following items are covered by Medicaid but not covered by Medicare and may be billed directly to Medicaid without an EOB. Refer to the DME SMAP for prior authorization requirements.

| HCPCS | MOD | DESCRIPTION |
|---|---|---|
| A4223 | NU | INFUSION SUPPLIES (USED WITHOUT PUMP) (Eff.04/16) |
| A4500 | NU | SURGICAL STOCKINGS, BELOW KNEE LENGTH |
| A4504 | NU | ABSORPTIVE DRESSING/HYDROACTIVE |
| A4510 | NU | SURGICAL STOCKINGS, FULL LENGTH |
| A4495 | NU | SURGICAL STOCKINGS, THIGH LENGTH |
| E0241 | NU | BATHTUB WALL RAIL |
| E0243 | NU | TOILET RAIL |
| E0244 | NU | RAISED TOILET SEAT WITH CLAMPS |
| E0245 | NU | TUB STOOL OR BENCH |
| E0246 | NU | SEAT WITH CLAMPS/BATHTUB TRANSFER |

805.5 Nursing Home Residents Transitioning to the Community

Members transitioning from a nursing home to the community must have an approved Care Plan/Individual Service Plan (ISP) for placement or community-based services by the case manager/support coordinator. The DME vendor may assess the member for complex rehab or other equipment, devices or supplies and obtain prior approval for the items necessary for the community setting. Approved DME and/or supplies must be delivered to the community home and reported with the appropriate place of service indicating where the item was issued for use.

806. Equipment Rentals and Purchases

It is the responsibility of the provider to verify Medicaid/PeachCare for Kids eligibility on each date of service. (Part I Policies and Procedures for Medicaid/PeachCare for Kids, Section 107.1).

For instance, if a member is shown to be nursing home eligible, the provider will need to discontinue billing until the member has been discharged from the nursing facility. The Department does not reimburse under the DME program for supplies or equipment for members residing in a nursing home or other institution.

Suppliers are NOT permitted to bill for rental and/or purchase of the same/similar piece of equipment in the same month.

## CHAPTER 900
## SCOPE OF SERVICES

### 901. General (Rev. 04/13) (07/18)

The Durable Medical Equipment (DME) Program reimburses providers for the purchase or rental of certain medical equipment and accessories, and the purchase of certain supplies for a patient's use in a non-institutional setting. The items must be prescribed by the physician treating the condition for which they are prescribed, and generally do not have value to patients in the absence of illness or injury.

Durable Medical is covered for Members in hospice when the item is ordered for non-hospice related medical conditions. The hospice agency is responsible for all services related to the terminal illness and any condition related to the terminal illness, including inpatient care and outpatient services. If services are required by a hospice patient and the medical necessity is unrelated to the hospice diagnosis, the provider of that service must first contact the hospice agency to obtain the hospice diagnosis information prior to submitting a request for prior authorization for the service. Diagnosis codes in the same family of codes as the hospice diagnosis will not qualify for separate reimbursement for durable medical equipment or supplies. (Rev. 01/14)

Example:

Hospice Diagnosis: Respiratory Failure

Equipment submitted by DME Provider: E1390 Oxygen Concentrator

Outcome: Denied- Hospice must provide equipment related to respiratory issues. Therefore, this will not be separately reimbursed to a DME provider by Georgia Medicaid. Hospice may reimburse the DME provider.

A **DMA-521 Hospice Referral Form** must be attached to the Prior Authorization Request and to the claim in the event the item is approved and considered to be separately reimbursed by the Department.

### 902. Coverage Guidelines for Durable Medical Equipment (Rev, 04/16) (07/18)

The Department will reimburse Durable Medical Equipment in accordance with the following conditions:

The equipment is appropriate for non-institutional use (non-facility equipment) and is required by the member for use in the home and/or community to treat illnesses, injuries, and assist in achieving the normal activities of daily living. A setting that functions primarily as a hospital or nursing facility for inpatients is not considered the member's residence and will result in the denial of services unless policy specifically

designates a nursing facility or skilled nursing facility (place of service 31/32) as a covered place of service for the item requested. (Rev, 04/16)

902.1 Coverage for Durable Medical Equipment and Supplies will be considered if the place of service is: (Rev,10/13, 04/16)

Coverage for DMEPOS items will be considered if the place of service is:

01 – Pharmacy
04 – Homeless Shelter
09 – Prison/Correctional Facility
12 – Home
13 – Assisted Living Facility
14 – Group Home
33 – Custodial Care Facility
54 – Intermediate Care Facility/Mentally Retarded
55 – Residential Substance Abuse Treatment Facility
56 – Psychiatric Residential Treatment Center
65 – End Stage Renal Disease (ESRD) Treatment Facility (valid POS for Parenteral Nutritional Therapy ONLY)

Coverage consideration for DME items in a Skilled Nursing Facility (31) or Nursing Facility (32) is limited to the following:

i. Custom Wheelchairs (*under 21 only*)
ii. Enteral Nutrition

902.2 Guidelines for billing services for members locked into home health:

Members who are locked-in to Home Health will qualify for coverage of durable medical equipment and supplies that are to be used in the home or community setting as deemed medically necessary by the ordering physician. All items required for the home health agency to perform the activities for which they are reimbursed (gloves, paper towels, wound care items such as gauze, tape, etc.) are included in the reimbursement for home health services, and all items used by the member such as wheelchairs, walkers, urological supplies, gauze and wound care supplies for dressing changes, and any other equipment or supplies required by the member and performed by the member or caregiver are covered through the DME program if the item is medically necessary and all policy guidelines have been met.

902.3 Durable Medical Equipment is defined as medical equipment that is appropriate for use in any setting in which normal activities of daily living occur, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting which payment is or could be made under Medicaid for inpatient services that include room and board. Durable medical equipment and

supplies must be furnished by a provider of durable medical equipment or a home health agency for use in the home and/or community and must meet the following conditions (Rev. 04/16):

i. Can withstand repeated use.
ii. Requires a prescription.
iii. Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years.
iv. Is primarily and customarily used to serve a medical purpose (requires order from a physician treating the condition for which it is required.
v. Generally, of no use to an individual in the absence of illness or injury.
vi. Is appropriate for in-home and/or community use to treat an illness or injury or to allow the member to participate in the normal activities of daily living, and typically does not require a skilled medical professional (used primarily by member or caregiver). (Rev. 04/16)

902.4 DME Supplies are defined as health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury. These items are reimbursed by Georgia Medicaid on a monthly basis, and typically require a prior authorization which may be approved for up to 12 months depending on the prescribed length of need, and actual items ordered by the physician. (Rev. 07/18)

902.5 Equipment and Supplies must be medically necessary to be reimbursed by the Department. Medical necessity is established by the physician's detailed written order (DWO) and/or certificate of medical necessity (CMN), based on the results of a face-to-face encounter with the ordering physician. The physician orders the equipment or supplies should be the physician who is treating the condition for which it is required. A detailed written order or certificate of medical necessity must document the member's qualifying diagnoses, any physical limitations that support the medical necessity, the member's height, and weight (supports a change in need based on growth/weight gain in most cases for members under 21 years of age), member's prognosis based on current medical conditions, and length of need for the items ordered. (Rev. 04/13, 04/14)

Georgia Medicaid does not provide reimbursement for used equipment; therefore, ALL equipment must be issued with a warranty. Providers must honor all warranties expressed or implied under applicable law. The warranty begins on the date of delivery (date of service delivered and signed for by the member or caregiver) and must be kept on file by the provider. A copy of the original warranty may be requested by the Department if the provider is audited. Providers of complex rehab

must follow policy guidelines that are applicable to the actual equipment they are providing as seen in 902.6. (Rev. 04/14)

Providers of Custom Seating and Custom/Complex Mobility systems must stand behind a two-year warranty for the major components of custom/complex wheelchairs and includes, but is not limited to the following:

Manual wheelchair base: must have a lifetime warranty on the frame of the wheelchair that protects against defects in the frame, components, and material for the duration of the designated reasonable useful lifetime (refer to the policy and/or schedule of maximum allowable payments (SMAP) for information on the reasonable useful lifetime). (Rev. 04/14)

- Excludes tires, casters, upholstery, and other consumable items, and damage caused by neglect, misuse, or improper installation, repairs, or adjustments performed by the member, their family, or another provider.

Power wheelchair: must have a lifetime warranty on the frame of the wheelchair that protects against defects in the frame, components and material, and workmanship for the reasonable useful lifetime of the device. Additionally, power mobility equipment must provide the following warranty (Rev. 04/14):

- Main electronic controllers must have a two-year warranty from the date of delivery to the member (signature and date on delivery ticket)
- Motors, gear boxes, and joysticks must have a two-year warranty from date of delivery (signature and date on delivery ticket)
- Custom cushions (E2617, E2609) and seating systems must have a two-year warranty or full replacement for manufacturer defects or surfaces that are not sufficiently durable to last two years under normal circumstances or normal wear.
- Excludes tires, casters, upholstery, and other consumable items and damage caused by neglect, misuse, or improper installation, repairs, or adjustments performed by the member, their family, or another provider.

## 902.6 Face to Face (F2F) Encounter Requirements (Effective July 1, 2011)

(Rev. 10/13, 04/11, 04/15)

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary before writing orders for DME or supplies. The encounter should meet all of the following requirements:

The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the start date of the written order.

This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) ordered.

A new face-to-face examination is required each time a new prescription for base durable medical equipment or consumable items that are not supply codes for the base equipment (example: F2F is required prior to an initial order or when PA expires and physician reorders urological supplies, enteral nutrition, ostomy supplies, etc.) is ordered. Supplies for base equipment are typically “A” codes such as items used in conjunction with a nebulizer or CPAP and are covered under the face to face for the base equipment for up to 12 months or until the actual order expires; whichever comes first. Providers are reminded that although they do not require a “separate” face to face evaluation, when the order for the items expires, if the member has not been seen face to face by the treating physician within the previous six months, then a face-to-face evaluation must be performed and be on file and available if requested during a request for prior approval or during an audit by the Department.

A NEW FACE TO FACE IS REQUIRED FOR THE FOLLOWING:

- All initial orders for the purchase or rental of base DME and/or consumable supplies
- When a member has not had a face-to-face evaluation within 6 months of an initial order or re-order of equipment or supplies
- When an item that is considered base equipment is replaced
- When there is a change in the supplier
- When required by state law

ALL base durable medical equipment requires an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) ordered. A dispensing order is not sufficient to provide these items with the exception of respiratory related equipment that is ordered at the time of discharge (verbal order accepted, but prior approval and written order is required prior to claims submission). Otherwise, a written Order Prior to Delivery (WOPD) is required.

ALL orders for consumable supplies require an initial face to face evaluation within 6 months prior to the order and require a new face to face evaluation after the expiration of the initial order, which is **not to exceed 12 months**, per Georgia Medicaid policy.

This should not be interpreted as requiring a F2F be performed every 6 months for items that were already approved for a period greater than 6 months but equal to or less than 12 months.

**Example 1- F2F required**

Physician orders wound care supplies with a length of need of 3 months and a prior authorization is granted the requested 3 months- A F2F IS REQUIRED- member must see the physician to provide evidence that the items are deemed medically necessary based on a face-to-face evaluation by the physician

**Example 2- F2F required**

Physician orders an oxygen concentrator with a length of need 99- for member expected to remain oxygen dependent. Prior authorization is approved the maximum allowed which is 12 months. A F2F IS REQUIRED- A face to face is required either upon expiration of the order OR every 12 months; whichever comes first.

**Example 3- F2F not required**

Physician orders power wheelchair and performs F2F evaluation within the previous 6 months and the power wheelchair was approved. Two months after the initial order for the wheelchair physician orders a seat cushion or headrest- F2F is not required, but dispensing order from the physician must be written and on file.

A NEW F2F IS NOT REQUIRED:

- When there is a change in the order for an accessory or supply when they are additions to an order for base equipment for which there was a face-to-face visit in the previous six months. A physician can order these items without a new face to face.

- For repairs of standard items that do not require a PT/OT evaluation. Seating systems and custom/complex equipment requiring a PT/OT evaluation must comply with those requirements.
- Every six months in general or in absence of an order for equipment or supplies or during an approved prior authorization period of no greater than 12 months

## 903.1 Documentation Required for Face-to-Face Encounters for Durable Medical Equipment

Georgia Medicaid requires that a physician must document that a physician, or a nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the member to assess the need for durable medical equipment

(DME) and/or supplies. The encounter must occur within the 6 months before the order is written for the DME or supplies.

Providers are required to have a detailed written order on file prior to submitting a request for prior authorization for all items that require a PA, and any items that are considered base equipment and do not require a PA. For supplies and accessories that do not meet the definition of base equipment, providers must have a written order on file within 30 days. In this case, the start date on the order must be **on or before** the delivery date, and the physician's signature will be the actual date the order was signed (not to exceed 30 days from the start date of the order). The face-to-face evaluation and associated order for equipment and/or supplies must be received by the DME provider within 30 days from the date the physician signs the order.

Providers are encouraged to use the form provided by the Department or similar (see appendix G), to ensure they have the documentation on file for auditing purposes. Providers must attest that a face-to-face encounter has occurred during the prior authorization process and must provide the correct date in order to comply with policy guidelines. As with all documentation contained in the medical record, providers must keep this documentation on file for no less than 5 years.

Alliant Health Solutions, the Department's quality improvement organization, requires providers to attest to a face-to-face encounter on all prior authorization requests. An Attestation Statement must be submitted, which requires a "Yes" or "No" response and the date of the patient's last office visit. The face-to-face encounter may also be made through the use of telehealth technology by reporting the appropriate Evaluation and Management (E&M) code. All documentation must be retained in the patient's record for a minimum of six (6) years and made available to the Department upon request. (Rev. 07/15)

*For more information on the Affordable Health Care for All Americans Act, refer to the following website:* **http://www.healthreform.gov/health_reform_and_hhs.html**

## 904. Coverage for Medical Supplies (Rev. 04/15)

Medical supplies are reimbursed when they are ordered by the physician treating the condition for which they are required. Providers must refer to the schedule of maximum allowable payments to determine if prior authorization is required. Supplies include, but are not limited to:

- surgical dressings/ wound care supplies (excludes secondary coverings: ace bandages, spank boots, knee supports, surgical leggings, gauntlets, pressure garments for hand and arms)
- Ostomy Supplies
- Urological Supplies

- Tracheostomy Care Supplies
- Enteral/Parental Supplies
- wound care supplies
- Wide variety of “A” HCPCS codes which are used in conjunction with base DME

DME supplies are limited to the maximum allowed units issued by CMS’ NCCI-Medically Unlikely edits, Georgia Medicaid Policy (see SMAP) or the quantity ordered by the treating physician. Overutilization may be requested through the prior authorization process and will be approved on a case-by-case basis if it is medically necessary.

In some cases, supplies may be approved for up to 12 continuous months before the supplies must be reauthorized. This is typically done for long term user of enteral nutrition, ostomy supplies, and urological supplies (quadriplegics with neurogenic bladder). All orders for supplies must be valid for the date of service billed. Orders must be renewed at least every 12 months or less depending on the duration of the actual order. All orders for supplies and clinical documentation supporting medical necessity of the supplies must be kept on file for a minimum of 5 years.

Prescription refills must be performed and recorded in a manner consistent with current State and Federal Laws, Rules and Regulations.

Providers may only submit claims for the actual quantity of supplies that are provided to the member regardless of the units approved on a prior authorization and may not bill in excess of the units approved on a monthly basis as the units approved on the prior authorization span the across the number of months requested. Supplies that typically do not require a prior authorization will be subject to a prior authorization if the request exceeds the maximum units allowed on the SMAP. Requests for approval of overutilization must be supported by a detailed written order that includes justification of the need. Medical necessity will be determined on a case-by-case basis.

## LIMITATIONS AND RESTRICTIONS

Providers must prorate the number of units submitted when they are providing less than a full month of the supplies for which they are being reimbursed.

Providers may not bill the Department for supplies used to perform home health services. This does not limit coverage of supplies used in the home in absence of the home health nurse or caregiver when a member is receiving home health

services. Durable Medical Equipment and supplies that are used by the member or caregiver will be reimbursed if policy guidelines are met.

Example:

Not Covered Under DME Benefit:

A home health nurse changes the dressings for a member with an extensive wound. This service and related Supplies must be provided by the home health agency.

Covered under the DME Benefit:

Same member receives additional dressing changes three times a week by his family members in absence of the home health agency.

*Automatic refills are prohibited. An automatic refill is any order that is shipped out automatically without contact with the member to confirm that the existing supplies are near exhaustion and to ensure they are still necessary.

**Effective 07/01/2015:** Providers should have a call log in the member's file for auditing purposes when the items are mail ordered and there is no signed and dated delivery ticket on file, but rather tracking information. (Added 04/15)

## 905. Non-Covered Services (Rev. 10/13, 04/15, 04/18, 01/20, 10/22)

Items considered non-covered include but are not limited to the following:

- Devices and equipment that are primarily and customarily used for non-medical purposes or are not medical in nature.

- Supplies used by employees of Home Health Agencies to perform services for which they are reimbursed by the Department under Home Health Benefit (wound care supplies, gloves, paper towels, etc.)

- Environmental control equipment (air conditioners, dehumidifiers, air filters or purifiers)

- Comfort or convenience items, or items that are primarily to assist the caregiver (vibrating beds, over-the-bed trays, chair lifts, bathtub lifts)

- Institutional-type equipment (oscillating bed, cardiac or breathing monitor (excludes infant apnea monitors and ventilators)

- Equipment requiring physician supervision or use of trained medical personnel (EKG monitor, oscillating bed, laboratory equipment, etc.)

- Physical fitness equipment (bicycles, treadmills, etc.)
- Most self-help devices (Braille teaching texts)
- Personal comfort items (radios, televisions, etc.)
- Precautionary equipment (preset portable oxygen units)
- Nutritional supplements, medical foods, and formula for members who eat by mouth (excludes genetic metabolic diseases [PKU] refer to policy)
- Furnishing type equipment (infant cribs and car seats)
- Incontinence Items (diapers, pads, adult briefs, disposable wipes)
- Reimbursement of mileage for delivery or repairs of equipment, and shipping fees
- Equipment considered investigational in nature or not FDA approved
- Equipment issued for a purpose where the medical effectiveness is not supported by evidence-based clinical guidelines
- Blood pressure monitors and weight scales
- Miscellaneous items billed under K0108 that are not included on the table of approved items in Appendix E.
- Items or services billed with a miscellaneous code when there is a HCPCS code that meets the description of the item or service (to avoid using the actual code because it is non-covered)
- Services billed using invalid, deleted, or non-covered HCPCS codes
- Wheelchairs or mobility devices that are ordered for outdoor use only
- Code combinations on the CMS NCCI procedure to procedure table as not payable when billed together (the lesser code denies) and codes that are billed in excess of the maximum units allowed on the MUE (medically unlikely edits) table

- Items billed in excess of published policy guidelines (Medicaid Policy) or listed on the schedule of maximum allowable payments with limitations

- Codes billed without prior authorization when the requirement exists

If coverage is uncertain, then providers should call the prior authorization team, Alliant Health Solutions, at 1-800-766-4456 to inquire. Alliant will contact the Department if this cannot be determined.

**EPSDT Consideration for members under 21:**

For members under 21 years of age, where EPSDT (Early Periodic Screening and Diagnostic Testing) exceptions may apply, please refer to the EPSDT Services – Health Check Program Manual located under Provider Information → Provider Manuals at www.mmis.georgia.gov.

Since these items are not covered for members over 21-years of age, or on a general basis for members under 21-years, providers must ensure the following: the item is considered durable medical equipment, there is a current order prescribed by a physician, and a prior authorization must be submitted which includes documentation of medical necessity for services to be considered for coverage. The prior authorization should include a three (3) component invoice (MSRP, Primary Discount, and Net Cost). If the medical equipment has no HCPCS code, or the code is not open for coverage, then the prior authorization must be submitted using HCPCS code E1399.

The following procedures are general DME services with unique HCPCS codes but are without Medicare based or nationally accepted rates. These HCPCS codes require a prior authorization (PA).

**FAILURE TO OBTAIN PRIOR APPROVAL BEFORE RENDERING / DELIVERING THE SERVICE / SUPPLIES WILL RESULT IN CLAIM DENIAL**.

Listed in this section are procedures restricted to the use of children between 2-years to 21-years of age. Children under the age of 2-years will be considered for coverage on a case-by-case basis for medical necessity.

**Note:** The prior authorization request must include one of the following; a letter of medical necessity or specific medical documentation that supports medical necessity.

The Division's reimbursement rates are listed on the Schedule of Maximum Allowable Payments (SMAP-DME) located under Provider Information → Fee Schedules at www.mmis.georgia.gov.

| HCPCS Code | Description |
|---|---|
| T4521 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH |
| T4522 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH |
| T4523 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH |
| T4524 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH |
| T4525 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH |
| T4526 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH |
| T4527 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH |
| T4528 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA-LARGE SIZE, EACH |
| T4529 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH |
| T4530 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE SIZE, EACH |
| T4531 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE, EACH |
| T4532 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH |
| T4533 | YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH |
| T4534 | YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH |
| T4535 | DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR INCONTINENCE, EACH |
| T4541 | INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, LARGE, EACH |
| T4544 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, ABOVE EXTRA LARGE, EACH |

## 906. Durable Medical Equipment Purchases (NU) Guidelines-

In certain instances, Durable Medical Equipment may be covered as a purchase (NU) when it is requested by a physician for a length of need meeting or exceeding ten (10) months, or when the item is inexpensive and routinely purchased.

All purchased equipment has a reasonable useful lifetime which is provided on a code specific basis on the Schedule of Maximum Allowable Payments, or in some cases in the policy manual.

The reasonable useful lifetime is the amount of time the item must be in use or is expected to last (durable) before Georgia Medicaid will allow the item to be replaced.

The Department only reimburses for the purchase of new equipment that is under warranty.

Purchase Reimbursement Includes:

- Delivery
- Assembly
- Training on use of the equipment or supply
- Adjustments if required

## 907. Durable Medical Equipment Rental (RR) Guidelines (Rev. 07/13, 04/15)

Providers must submit a prior authorization request for approval of all requests for rental (RR) durable medical equipment.

### Capped Rental Guidelines

Items that are considered to be capped rentals are covered for a period of ten (10) rental months, and then ownership of the equipment transfers to the member and no additional rental months will be covered for the duration of the reasonable useful lifetime of the equipment. All associated labor, repairs, or replacements during the rental period are included in the monthly rental fee.

In some cases, accessories may be separately payable during the rental period of the base equipment. Providers must review and comply with all policy guidelines for the actual policy for which they are providing services.

Items that have a physician documented length of need that exceeds ten (10) months may be submitted for purchase (NU) when this option is available (refer to the schedule of maximum allowable payments).

**Limitations:**

TENS Units are covered for 6 rentals and convert to purchase at that time.

Automatic external defibrillators (K0606) are covered initially for a 3-month rental period while waiting for the implantable device to be placed. If the surgery has not occurred the remaining 3 months may be requested through the prior authorization process.

**Indefinite Rentals**

Certain life-sustaining and/or respiratory related equipment is considered to be an indefinite rental. This means that providers will receive a monthly rental payment for each month the item is determined to be medically necessary. There is no separate reimbursement for supplies, servicing, replacement, labor, or repairs of indefinite rental equipment as this is considered to be included in the indefinite rental payment.

This equipment includes:

- Ventilators (E0465, E0466 rev. 01/16)
- Apnea Monitor (E0619)
- Oxygen Concentrators (E1390, E1391, E1392)
- Liquid Oxygen System (E0439)
- Portable Oxygen Systems and Contents (E0424, E0431, E0433, E0434, E0441, E0442)

**Rental Reimbursement Includes:**

- Delivery and/or Pickup
- Assembly/Setup
- Adjustments
- Training in use of the equipment
- Routine service and maintenance and repairs

## 908. Maintenance, Repairs, and Replacements

Routine maintenance, repairs, and replacements for rental equipment are the sole responsibility of the provider as items must be issued as new equipment and should be covered under a manufacturer's warranty during the 10-month rental period. Routine periodic servicing of equipment is noncovered with the exception of power mobility devices that are no longer covered under a warranty. In this case the wheelchair may be routinely serviced once per 6 months if it is reasonable and

necessary, is prior authorized by the Department, and the servicing is performed by a provider who is enrolled in Georgia Medicaid.

Repairs that are performed while the equipment is being rented do not require a prior authorization and do not require a detailed written order as these repairs are considered to be included in the rental reimbursement. Repairs to purchased equipment are covered only when a repair is necessary to make the equipment functional and the warranty has expired. All repairs for purchased equipment require a prior authorization. A detailed written order and/or certificate of medical necessity (CMN) are required for repairs and must be signed by a physician and submitted with the prior authorization request.

Requests for repairs of equipment that has been damaged due to the member's negligence or abuse will be denied, and the equipment will not be replaced by the Department before it's normal life expectancy (reasonable useful lifetime) has been attained.

Repairs are covered only for situations where the equipment has been reasonably worn or accidental damage has occurred, and the equipment needs to be restored to make the item functional. Providers must have on file a complete record of the description and justification of all repairs and labor charges submitted to the Department for reimbursement. Repairs are subject to post payment review, and the Department reserves the right to request this information.

Additional consideration should be given to the following when determining if a repair or replacement is appropriate:

**Repair of durable medical equipment is appropriate when:**

- Repairs are needed to make the equipment functional, due to reasonable wear and usage
- The DME being repaired is member-owned
- The item needs repair and the manufacturer's warranty has expired
- The repair cost is less than the replacement cost
- The repair is needed due to a change in the member's condition

Replacements are covered for the situations outlined below. If an incident occurred such as a fire or burglary, then the provider must submit the appropriate fire or police report supporting the claim for the replacement equipment. Equipment will not be replaced due to member's negligence and/or abuse (equipment left outside and stolen, struck by vehicle, lost/abandoned, etc.). If new equipment is requested as a replacement for existing equipment due to a change in medical condition, then the provider must submit all documentation required to obtain a new piece of equipment and the medical necessity for the change in equipment must be supported. Justification should be clearly stated as to why the existing equipment no longer

supports the functional needs of the member, and prior authorization must be obtained.

**Coding Guidelines for Repairs:**

The labor component for repairs is coded K0739 U1 (*Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component)*. K0739 U2 is reported in conjunction with K0739 U1 when repairs are for custom or specialty parts that do not have a HCPCS code. If modifier U2 is used to report custom repairs/parts, then an itemized list must be submitted, and the total price must be the submitted charge.

**K0739- U1** REPAIR OR NON-ROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT

**K0739- U2** MISCELLANEOUS PARTS BILLED AS A REPAIR IN CONJUNTION WITH LABOR (Manually priced by invoice)

**Limitations:**

- Do not report K0108 for parts being replaced.
- K0739-U1 is limited to the maximum units on the Table of Repairs with Allowed Units of Service (SEE 909)
- All repairs require prior authorization.

**Replacement of durable medical equipment is appropriate when:**

**a)** The item cannot be repaired due to reasonable deterioration over time or accidental damage
**b)** A natural disaster has occurred such as a fire or flood (and no other insurance is liable for damages)
**c)** The DME being replaced is member-owned
**d)** The item cannot be repaired, and the manufacturer's warranty has expired
**e)** The replacement cost is less than the repair cost
**f)** The replacement is needed due to a change in the member's condition and the current equipment is no longer effective.
**g)** Replacement of the DME item is subject to prior authorization and the need for the equipment must still exist.
**h)** The DME item is lost or stolen and not otherwise covered by another insurance (such as automobile, renter's, or homeowner's policy)

## 910. Reasonable Useful Lifetime (RUL) for Durable Medical Equipment (Rev.10/21)

For items not listed on this this table or for the RUL of a specific HCPCS code, please refer to the DME Schedule of Maximum Allowable Payments (SMAP). Durable medical equipment should be issued as new equipment and is expected last the duration of the reasonable useful lifetime. The expected lifetime of base durable

medical equipment is five (5) years or less in most cases, however, providers may not issue replacement equipment at these intervals as a standard practice, and the current equipment must no longer be functional for replacements to be considered medically necessary. This should be well documented and supported by meeting the policy standards as required for the issue of new equipment. (Rev. 04/16)

Wheelchair replacements for growing children will continue to be evaluated based on the medical documentation submitted for each individual case.

| Revision Dates | Durable Medical Equipment | Reasonable Useful Lifetime |
|---|---|---|
| 04/16 | Air Compressor/Generator | 5 Years |
| | Pediatric Gate Trainer | 3-5 Years |
| | Adult Wheelchair (21 or older) Power or Manual | 5 Years |
| 10/13 | Wheelchair Power or Manual (under 21) | 3-5 Years (case by case) |
| 01/14 | Pediatric Wheelchairs (KidKart etc.) | 2-3 Years |
| | Breast Pumps | 1-3 Years (one per qualifying pregnancy) |
| | Hospital Bed | 5 Years |
| 04/16 | Hospital Bed Mattresses | 4 Years |
| 04/08 | Group I Pressure Reducing Support Surfaces | 3 Years |
| 10/21 | Group II/III Pressure Reducing Support Surfaces | 3 Years |
| 04/16 | Hoyer Lift | 5 Years |
| | Oxygen Equipment (indefinite Rental) | 5 Years (or as needed) |
| 04/16 | Respiratory and Other Breathing Equipment | 4-5 Years |
| 07/13 | CPAP/BIPAP | 4-5 Years |
| | Suction Pumps | 3-5 Years |
| 10/13 | Inexpensive Routinely Purchased Equipment (Nebulizer/Walker/Bedside Commode, etc.) | 2-5 Years |
| | Crutches | 1-3 Years |
| 04/16 | PEN Infusion Pump | 5 Years |
| 01/08 | Insulin Infusion Pump | 4 Years |
| 01/11 | Speech Generating Devices | 3-5 Years |
| 07/14 | Stander | 3-5 Years |
| | Base Equipment without a designated reasonable useful lifetime | 3-5 Years |
| 10/14 | For replacement guidelines of supplies refer to the SMAP | See SMAP |

## 911. Temporary Out-Of-State Provider Limitations

Out-of-state providers not enrolled in the Georgia Medicaid Program may be temporarily enrolled as Participating Providers and will be reimbursed for covered services provided to eligible Georgia Medicaid members during periods of time for which they require medical services while out of state if the claim is received within 12 months from the month of service, and if at least one of the following conditions are met:

1) The service(s) was prior authorized by the Division (Alliant Health Solutions) and the provider is enrolled as a temporary Georgia Medicaid provider in the DME Program;
2) The service(s) was provided as a result of an emergency or life-threatening situation occurring out of state and the provider is enrolled as a temporary;
3) The service, if delayed, would endanger the health of the member.

Reimbursement and coverage for out of state providers are determined through the prior approval process, and the DME Schedule of Maximum Allowable Payments (SMAP) or policy guidelines for the actual service provided.

Note: Requests for prior approval must be submitted electronically effective December 1, 2014, through the web portal (www.mmis.georgia.gov), and questions regarding out of state prior approvals can be addressed by calling HP at 1-800-766-4456 and selecting the option for prior authorizations. Out of state claims must have a copy of the authorization letter attached if services were prior approved for the medical justification of the services was due to an emergency.

## 912. Enrolled Out-Of-State Provider Limitations

Providers that are located within fifty (50) miles of the State's border may be enrolled as participating Georgia Medicaid Providers. In limited instances, providers who render services where there is no equivalent in-state service may also be enrolled. Providers must follow all applicable in-state medical policy rules and regulations and are subject to prior authorization.

## 913. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe, and refer items or services for Medicaid

beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing, and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

## 914. Commonly Used Acronyms (Updated 1/18)

ACA - Affordable Care Act

ABN - Advanced Beneficiary Notice of Noncoverage

AMA - American Medical Association

ANSI - American National Standard Institute

CCN (ICN) – Claim Control Number

CFR - Code of Federal Regulations

CGM – Continuous Glucose Monitor

CMN - Certification of Medical Necessity

CMS - Centers for Medicare & Medicaid Services

CMS-1500 - Health Insurance Claim Form

CPAP - Continuous Positive Airway Pressure

CPT – Current Procedural Terminology

DCH – Department of Community Health

DHHS - Department of Health and Human Services

DME - Durable Medical Equipment

DMEPOS – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

DO - Doctor of Osteopathy

DOB - Date of Birth

DOS - Date of Service

EDI - Electronic Data Interchange

EOB - Explanation of Benefits

ERA - Electronic Remittance Advice

ESRD - End Stage Renal Disease

FDA – U.S. Food and Drug Administration

FFS - Fee-for-Service

GAMES- Georgia Association of Medical Equipment Suppliers

HCPCS - Healthcare Common Procedure Coding System

HHA - Home Health Agency

HHS - Health and Human Services

HIPAA - Health Insurance Portability and Accountability Act

HME- Home Medical Equipment

HMO – Health Maintenance Organization

HICN- Health Insurance Claim Number

ICD-9-CM - International Classification of Diseases, 9th Revision, Clinical Modification

ICD-10-CM - International Classification of Diseases, 10th Revision, Clinical Modification

ICN- Internal Control Number

IDPN - Intradialytic Parenteral Nutrition

IDTF- Independent Diagnostic Testing Facility

IHS- Indian Health Service

IPPB – Intermittent Positive Pressure Breathing

IRP –Inexpensive or Routinely Purchased DME

IV – Intravenous

LCA – Least Costly Alternative

LON – Length of Need

MAE- Mobility Assistive Equipment

MFCU – Medicaid Fraud Control Unit

MR – Medical Review

MRADL – Mobility Related Activities of Daily Living

MS – Maintenance and Servicing

MSP – Medicare Secondary Payer

MUE – Medically Unlikely Edit

NCCI – National Correct Coding Initiative

NICU – Neonatal, Intensive Care Unit

NPI – National Provider Identifier

NPWT – Negative Pressure Wound Therapy

OD – Doctor of Optometry (Optometrist)

OIG – Office of Inspector General

PEN – Parenteral and Enteral Nutrition

PHI – Protected Health Information

PI – Program Integrity

PMD – Power Mobility Devices

POS – Place of Service

POV – Power Operated Vehicle

PTP – Procedure to Procedure

RA – Remittance Advice

RAD – Respiratory Assist Device

SGD- Speech Generating Device

SLM- Seat Lift Mechanism

SMAP- Schedule of Maximum Allowable Payments

SNF – Skilled Nursing Facility

SSA- Social Security Administration

TENS – Transcutaneous Electrical Nerve Stimulator

TPL – Third Party Liability

TPN – Total Parenteral Nutrition

## CHAPTER 1000
## BASIS FOR REIMBURSEMENT

### 1001. Durable Medical Equipment Services

The maximum reimbursement for providers of durable medical equipment is limited to the lower of:

a) The actual approved charges for the item; or
b) 80% of the 2007 DMEPOS rate

### 1001.1 Member co-payments for (FFS) Medicaid:

**Member co-payment:** Effective for dates of service July 1, 1994, and after, for members 21 years of age and older, a $3.00 co-payment will be applied to all DME services with the modifier NU except for DME supply procedure codes (“A” codes). Procedure codes E0441 and E0442 are exempt from co-payment. A $3.00 co-payment will be applied to the following rental procedure codes: E1390 RR, E1391 RR, E1392 RR, E0424 RR, E0431 RR, E0434 RR, E0439 RR, E0439 QE, E0439 QF, E0465 RR, E0466 RR, E0470 RR and E0784 RR. A $1.00 co-payment will be applied to all other procedure codes that have a modifier of RR. (Rev. 04/20)

| **ILLUSTRATIVE CO-PAYMENTS** | |
|---|---|
| Durable Medical Equipment Rentals (RR) (excludes oxygen – Per Month | $1.00 |
| Durable Medical Equipment Purchases (NU) – Per item | $3.00 |
| Durable Medical Equipment- Portable or Stationary Oxygen Rentals (RR) | $3.00 |
| Oxygen Contents- E0441 and E0442 | No co-pay |
| Durable Medical Equipment-Supplies (“A”) codes | No co-pay |

1001.2 **Member co-payments for PeachCare for Kids:**

Effective for services provided on or after April 1, 2012, the Georgia Department of Community Health will implement co-payments for covered services to PeachCare for Kids members 6 years of age or older.

The co-payments are subject to rates. Co-payments will be deducted from the amount paid on approved claims (Rev. 10/17)

Co-payments are not required for children who are American Indians or Alaska Natives. Providers may not deny services to any eligible PeachCare for Kids member due to the inability to pay the co-payment amount. The provider should check member eligibility in order to identify those individuals who may be responsible for co-payments. If you have questions, contact HP Enterprise Services Contact Center at (800) 766-4456.

Listed below are the PeachCare for Kids co-payment amounts:

| **ILLUSTRATIVE CO-PAYMENTS** | |
|---|---|
| Durable Medical Equipment Rentals (RR) (excludes oxygen – Per Month | $1.00 |
| Durable Medical Equipment Purchases (NU) – Per item | $3.00 |
| Durable Medical Equipment- Portable or Stationary Oxygen Rentals (RR) | $3.00 |
| Oxygen Contents- E0441 and E0442 | No co-pay |
| Durable Medical Equipment-Supplies (“A”) codes | No co-pay |

## CHAPTER 1100
## MEDICAL POLICIES AND SPECIAL COVERAGE CONSIDERATIONS

**The Division of Medical Assistance Plans may reimburse for durable medical equipment and medical supplies when furnished by a provider of Durable Medical Equipment Services who is enrolled with Georgia Medicaid, and the item meets all of the following criteria:**

(a) Ordered by a physician treating the condition for which it is requested;
(b) Ordering physician has had a face-to-face encounter with the member within the six months prior to ordering the equipment;
(c) Has been approved by the FDA and is otherwise considered to be safe and effective for in-home use to treat the condition for which it was prescribed;
(d) Is medically necessary and appropriate for use in the home setting by the individual or caregiver;
(e) Is the least costly and most appropriate alternative;
(f) Is primarily used to serve a medical purpose, and requires a prescription;
(g) Is not generally of use to a person in absence of illness or injury;
(h) Can withstand repeated use (non-consumable durable medical equipment);
(i) Meets coverage criteria as specified by the Department or Prior Authorization Review criteria for medical necessity;
(j) Does not exceed service limitations or rules;
(k) Has been prior authorized if required;
(l) Is not included in an all-inclusive rate in a nursing or skilled nursing facility or as part of a home and community-based care waiver
(m) Proof of delivery signed/dated by the member or caregiver and must be on file as evidence that the service was performed and is reimbursable by the Department.

Chapter 1100 contains a listing of medical policies and applicable coverage criteria. This information is updated on a quarterly basis and is subject to change. Providers should review this information on a regular basis to ensure they are following current policies and procedures based on the actual date of service for the items provided. Providers should be aware that all supporting medical documentation for approved durable medical equipment and supplies must be on file for no less than six (6) years and must be made available upon request.

| POLICY 1101 | AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) DEVICES (Rev. 07/13, 01/15, 04/15) |
|---|---|

Speech generating devices (E2500-E2510) provide a means of communication for individuals with severe speech impairments and developmental delays. These devices support the functional speaking and expressive needs that are required to communicate and participate in normal activities of daily living in both the home and community.

These devices are covered if a member meets the coverage guidelines expressed in this policy and is ordered by a physician in collaboration with the member's speech language pathologist, and the device meets the criteria for coverage as a speech generating device.

**General Provisions for Speech Generating Devices**

a) Purchase, rental, replacement, and repair of a Speech Generating Device (SGD) use for Augmentative and Alternative Communication, (AAC) devices and accessories are reimbursed through the Durable Medical Equipment program and are subject to the limitations set forth within.

b) All Medicaid members shall be eligible to receive a speech generating device as prescribed by a physician in accordance with the requirements and limitations set forth herein.

c) All requests for speech generating devices, software, applications, accessories and/or attachments shall be reviewed for medical necessity, as defined in Section 1102 herein, and the other requirements set forth herein.

d) All required supporting documentation, as more clearly set forth herein, must be submitted prior to the Department's review of any claim for a speech generating device.

e) When a speech therapy device is requested for an individual under the age of twenty-one (21) and the individual is attending school, a copy of the member's most current individualized educational plan, if applicable, must be submitted along with the AAC evaluation for the speech therapy device; and identification of the vendor providing the recommended speech therapy device and/or service and their cost (DME providers must provide a warranty for their products according to the Georgia Assistive Technology Act of 1993.)

**Definitions**

a) **Speech Generating Device (SGD) for Augmentative and Alternative Communication (AAC):** electronic or non-electronic aids, devices or systems that correct expressive communication disability that precludes effective communication of messages, in the form most appropriate to the beneficiary and

meaningful participation of daily activities. Augmentative communication devices include both dedicated voice output communication devices, certain types of qualifying mobile devices, and computer-based devices that have been modified so that they

b) **Accessories for Speech Generating Devices:** device related components, including computer software, symbol sets, overlays, mounting devices, switches, cables, and connectors (included in reimbursement for SGD), auditory, visual and tactile output devices, and related follow up training for the member to use the SGD device to effectively meet his or her communication needs.

c) **Augmentative Communication Evaluation for a Speech Generating Device:** An evaluation, provided in written form, acceptable to the Department that accompanies a prior authorization request for a SGD, accessory and/or service. The assessment shall be conducted by a speech-language pathologist (SLP) as defined in 42 C.F.R. Section 440-110©, who also holds a Georgia license to practice. The assessment may be performed in conjunction with other appropriate licensed practitioners of the healing arts acting within the scope of their practice.

d) **Medical Necessity:** All requests for speech generating devices (SGD), accessories or attachments shall be reviewed for Medical Necessity as the term shall be defined in Part I, Policies and Procedures, Section 106.12, applicable to all providers, and the requirements set forth herein. Section 106.12 currently defines Medically Necessary services "as those covered services which are reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions. Services meeting professional standards are those which, in the opinion of a recognized peer, under usual circumstances, contribute to a satisfactory outcome in the health status of the member. The services provided, as well as the type of provider and setting must be appropriate to the specific medical needs of the member; and there must be no other equally effective, more conservative, or substantially less costly course of treatment available. The determination of medical necessity shall be made in accordance with currently accepted standards for medical practice."

   Should the definition of medical necessity set forth in Section 106.12 be changed or modified in any way, those changes or modifications shall apply to claims for speech generating devices, accessories, and services.

**Noncovered Items**

The following equipment, items and services are noncovered:

a) Extended warranty and maintenance agreements (Excludes tablets or equivalent which require a 3-year loss insurance policy at time of purchase).
b) Shipping and handling fees on purchased equipment.

c) Computer equipment, software and applications, and accessories that are not ordered by a physician for therapeutic use of the member's communication device.
d) Replacement or repairs of equipment being rented.
e) Replacement or repairs of tablets or equivalent covered as an SGD for AAC services.
f) Equipment replacement or repair that is necessitated by member neglect, wrongful disposition, intentional misuse, or abuse.
g) Equipment that is considered same or similar to equipment already funded by Medicaid either through the Early Intervention Screening and Diagnosis Program or through Medical Assistance Services provided by educational agencies, unless such equipment is required by clinical justification of needs and represents the least costly alternative in equipment options for the individual.
h) Second speech generating device unless such devices are medically necessary, through justification of clinical needs in order to functionally communicate and represent the most appropriate, least costly alternative in equipment options for the member.
i) Replacement of a member's existing speech generating device when the replacement is requested solely as a result of changing technology.
j) Equipment that is not NEW when provided to the Medicaid beneficiary. This includes "demos" or any equipment that is issued after the warranty has begun. (This does not apply to crossover claims where equipment may be billed as used).
k) Tablet or equivalent that does not have a 3-year accidental loss insurance plan at the time of purchase.

**Prior Authorization**

**a)** Providers of speech generating devices must request and obtain prior authorization for the purchase, rental, repair, replacement, or modification of speech generating devices, accessories, and attachments.

- No prior authorization is required for the repair or replacement of batteries for a speech generating device.

**b)** Prior authorization for purchases and rentals of speech generating devices, accessories or attachments shall include the following:

- A prescription from a physician that includes the device and components ordered.
- An evaluation for a speech generating device prepared by a Georgia licensed speech language pathologist that is enrolled in Georgia Medicaid.

**c)** Prior authorization requests for repair, replacement or modification of a speech generating device, accessories or attachments shall include the following:

- The reason for the repair, modification, or replacement, and if the speech generating device has been damaged, a letter from the speech-language pathologist explaining how the damage occurred;
- When the request is for the repair of a speech generating device, or for its replacement with a device, a letter from a licensed speech-language pathologist establishing the member's prognosis for continued use of the current device;

- When the request is for the replacement of an existing speech generating device with a same or similar device, in addition to the information required in 1102, a statement from a licensed speech-language pathologist of why replacement is required as compared to a repair of the existing device, and the replacement cost of the new device;

- When the request is for the replacement of an existing speech generating device with a different type of speech generating device, a letter from a licensed speech-language pathologist establishing why both repair and replacement with the same type of device is not appropriate, what the member's prognosis with the requested replacement device will be, and the cost of the new device. A change in the device or upgrade is only approved if the medical condition has significantly changed and the current device is not capable of providing the alternative augmentative communication for which it was ordered or if the current device has reached the reasonable useful lifetime;

**d)** The Department shall issue a decision either approving or denying the request for the purchase, rental, repair, replacement, or modification of a speech generating device, accessory, or attachment within thirty (30) days of receipt of the prior authorization request.

- When it is determined by the Department that a prior authorization request is incomplete or that additional information is needed in order to make an informed decision on a request for a speech generating device, the Department will request the missing or needed information from the speech-language pathologist who conducted the assessment for the device. If the Department must request missing or additional information from the SLP in order to make a decision, the thirty (30) daytime period shall not begin to run until the additional information is received by the Department.

**Required Data for a Speech Generating Device**

**a)** A prior authorization request for the device, accessories and/or attachments must be supported by the information described in this policy.

**b)** Treating Physician Information

The member's treating physician is required to submit the following information in support of prior authorization for a speech generating device, accessories and/or attachments.

Prescription/Order must meet the following criteria:

- Date on the order is within 6 months of the face-to-face visit
- has handwritten or electronic signature (not stamped) and date for all items requested;
- a description of the member's specific physical limitations and significant medical history pertaining to communication abilities and limitations;
- all supporting diagnoses or conditions supporting the medical necessity of the items ordered;
- a complete description of the speech generating device, accessories and/or attachments ordered;
- the anticipated length of need for the speech generating device, accessories and/or attachments;
- a statement of occurrence with the recommendation of the evaluation for a speech generating device

**c)** Speech-Language Pathologist (SLP) Information

The SLP and all other practitioners who submit information in support of the prior authorization request must describe his or her AAC services, training, and experience in addition to establishing their licensure and other credentials or qualifications. The SLP must assert that he or she has no financial interest in the outcome of the assessment.

**d)** SLP Evaluations for speech generating devices must contain, at a minimum, the following information:

- Member's medical diagnosis, including the member's communication diagnoses (dysarthria, apraxia, aphasia) with a rationale of the medical necessity for the device and components requested;
- Current communication impairment including the type, severity, language skills, cognitive ability, and anticipated course for the impairment;
- The member's prognosis with and without the aid of a speech generating device

- A description of the functional communication goals expected to be achieved through effective use of the device and accessories, and the treatment options, and plan of care;

- Rationale for the selection of a specific device, accessories, and/or software

- The cognitive and physical abilities to effectively use the device and accessories to functionally communicate, and any limitations or constraints affecting the use of the device;

- Any previous treatments of communication problems and why those treatments are not effective in permitting communication of messages in the form most appropriate to the member for meaningful use in daily activities;

- For a subsequent upgrade or replacement device, information regarding the functional benefit to the beneficiary of the upgrade compared to the previous device;

- current and projected language comprehension, expressive language capabilities, oral and motor speech status, visual capabilities, hearing capabilities, and the limitation of impairments in these areas which impact the member's expressive communication and prognosis;

- current communication abilities, behaviors and skills, and the limitations or impairments in these areas that interfere with meaningful participation in current and projected daily activities;

- description of the member's postural, mobility and motor status, including optimal positioning and integration of the speech generating device;

- a description of any trial period in which member utilized the speech generating device requested which demonstrates the member's ability and willingness to use the device effectively;

- a description of the recommended speech generating device and all requested components;

- an explanation as to why the recommended device represents the least costly, most appropriate, and equally effective treatment alternative;

**e)** An Augmentative and Alternative Communication (AAC) therapy treatment plan for the member which includes the following:

- the party responsible for delivering and programming the speech generating device;

- a statement as to who will train the member and communication partners in the proper use, programming, care, and maintenance of the speech generating device;

- the short and long-term goals and expected outcomes

- a description of the criteria to be used to measure the member's progress toward meeting both short and long-term communication goals and expected outcomes

**f)** The Alternative and Augmentative Communication assessment must also include an assessment of the specific speech therapy device, accessories and services being recommended which must contain the following information:

- vocabulary requirements

- representational systems

- display organization and features

- rate enhancement techniques

- message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output;

- access techniques and strategies

- portability and durability issues

- identify significant characteristics and features of the speech generating device, accessories and/or services;

- cost of the recommended device, accessories, and services;

- identification of alternative devices, accessories and/or interventions considered and an explanation of why the requested device, accessories and services are the least costly, most appropriate, and equally effective alternative to permit effective communication by the member; and

- whether purchase or rental is the most effective option.

**Third Party Liability**

For individuals who are members of health services from third party funding sources in addition to Medicaid, the documentation submitted with a prior authorization request must include a written decision from each third-party funding source regarding its willingness or refusal to pay for the speech generating device, accessory, or attachment.

**Trial Period**

An SLP may request that a speech generating device, accessory or attachment be provided on a trial basis prior to making a recommendation for purchase. A request for a trial period must be prior authorized, and supported by an AAC evaluation for the device, as described in 1105. The duration of the trial period may be between 30 to 90 days, at the discretion of the SLP. Results of trial periods for the speech generating device, accessories or attachments are to be included with any request for purchase of these items.

**Notice for Decision**

The Department shall provide written notice of every decision to approve or deny a prior authorization request for a speech generating device, accessories and/or services to the member, as well as to the speech-language pathologist who conducted the beneficiary's AAC assessment for the device.

**Limitations:**

- AAC devices will be considered noncovered if all policy specific guidelines are not met.
- AAC devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one AAC device will be covered per three-five (3-5) years. If less than five (5) years, then a rationale as to the lesser lifetime must be provided.

| POLICY 1101.1 | Mobile Devices with Qualifying Software covered as a Speech Generating Device (SGD) for Alternative Augmentative Communication (AAC) Therapy<br>(Implemented 04/14, Rev. 04/15) |
|---|---|

Due to emerging technology in speech therapy, Georgia Medicaid will consider coverage of Mobile Devices that have associated Alternative and Augmentative Communication Applications and Software available for use as a Speech Generating Device. All coverage requirements for standard speech generating devices listed in Chapter 1200, Part B apply to the coverage of this type of speech generating device as well as any additional requirements listed under section 1204. All codes associated with this type of Speech Generating Device must have a quote invoice submitted with the prior authorization request.

- Patients must meet all the policy requirements for a speech generating device as specified in this policy (Chapter 1200, Part B).

- The Mobile Device submitted must be the least costly alternative for that product category as this device should only support the application for speech therapy.

- A Detailed Written Order for the specific device and software or application must be submitted for approval

**Covered Device HCPCS/Modifier Combinations for Mobile Device and Software Applications used for AAC Therapy*:***

**E2510- U1** (Mobile Device used as speech generating device for AAC therapy with 3-year loss insurance) manually priced 40% above invoice- up to $1,000.00 for the device with 3-year loss insurance.

**E2511- U1** (AAC Software Application for use with Mobile Device used as speech generating device) manually priced 40% above invoice- Up to $450.00

**Covered Accessories for Qualifying a Mobile Device used as a SGD for AAC:**

**E2599- U1** (Heavy Duty protective case for Mobile Device used as a SGD) once per lifetime of device– manually priced 40% above invoice- Up to $150.00

**E2599- U2** (Replacement Charger/adapter for Mobile Device used as a SGD) once per year beginning 12 months after the date of purchase – manually priced 40% above invoice- Up to $70.00

**Coverage Guidelines**

**Coverage for a Mobile Device and appropriate software application will be considered for patients who:**

1) Had an assessment performed by a Speech Language Pathologist (SLP) for the use of this device/software application
(*SLPs must refer to the respective program manual for coding guidelines for this assessment 92607-U1)*

2) Have a treatment plan for therapy services for this particular device/software
*(SLPs must refer to the respective program manual for coding guidelines 92609-U1)*

3) Meet ALL coverage criteria for a standard speech generating device as referenced in this policy

4) Have a detailed written order from the treating physician for the device requested in the SLP's evaluation.

**Coding Guidelines for Mobile Devices used as Speech Generating Devices with Augmentative and Alternative Communication Software Applications:**

*The ordering provider must document the patient's willingness and ability to use this device.*

If E2510-U1 is billed without the associated AAC software (speech therapy software/application) E2511-U1, it will be denied as a noncovered device. A mobile device that is not used as a dedicated device (a dedicated device is a device that is used solely for the purpose for which it is prescribed) for speech therapy and does not have the required augmentative and alternative communication (AAC) software installed does not meet the definition of a speech generating device. Augmentative and Alternative Communication software applications (E2511-U1) may be billed without a speech generating device (E2510-U1) for a patient owned mobile device (i.e., funded through grants). The mobile device and software application will be considered for coverage if they meet the needs of the patient as reported in the Speech Language Pathologist's assessment and have been ordered by the treating physician after reviewing the SLPs assessment.

***Reasonable Useful Lifetime**: The reasonable useful lifetime of equipment issued as an "optionally dedicated" (non-dedicated devices such as tablets that have been ordered with AAC software to allow them to function as a SGD) speech generating device is 3-5 years. Any additional speech generating device billed during the reasonable useful lifetime will be denied as same or similar equipment. Medicaid will not replace this type of device before the 3-5-year reasonable useful lifetime for any reason other than a change in the patient's medical condition which no longer permits the patient to use the current device as a functional speech generating device.

***Replacement of the Device during the Reasonable Useful Lifetime**: The DME provider MUST purchase a 3-year accidental loss/damage insurance policy (this is offered by some retailers at the time of purchase or through a private carrier). The provider must replace the device through the loss insurance policy if necessary, during the three-year period for any reason including accidental loss/theft.

***Reimbursement**: The authorized payment for the device will be 40% above the

combined cost of the device and the accidental loss/damage insurance policy. Invoices for both components must be included in the documentation that is submitted for reimbursement. If both pieces of information are not present at the time the prior authorization is submitted, the device will be denied as it does not meet policy guidelines.

*__Accessories__: Heavy-duty carrying cases that include screen protection are covered during the initial purchase of the device only and will not be covered again during the reasonable useful lifetime of the device. A charger and/or charger/adapter combo can be replaced 1 time per year beginning 12 months after the purchase of the device if necessary.

* __Device Requirements__: This device must be used by the member as a “dedicated” device in order for the item to be considered for coverage. The software application for this device is covered once during the reasonable useful lifetime of the device and must be billed with the initial purchase of the qualifying mobile device.

*Georgia Medicaid does not reimburse for the costs of any type of internet services required to operate these devices and software applications. The applications and software should be operational without requiring internet services.

*The Speech Language Pathologist provides the initial setup, training on the usage of the device, and therapy services. This is the only time the ordered software application requires internet services.

**Limitations:**

- AAC devices will be considered noncovered if all policy specific guidelines are not met.
- AAC devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one AAC device will be covered per three-five (3-5) years. If less than five (5) years, then a rationale as to the lesser lifetime must be provided.

| POLICY 1101.2 | Speech Aid Devices (Rev. 04/13, 04/15) |
|---|---|

A speech aid device (artificial larynx) is a prosthetic device intended to assume some or all the function of the natural larynx. A natural larynx generates sound waves that in turn become speech. The natural larynx also controls the pitch and volume of the sounds it generates (voice). Sound waves travel from the larynx up to the throat and into the mouth where movement of the lips, teeth, palate, and tongue contribute to the final sound that generates natural speech. An artificial larynx may be electronically controlled or pneumatically controlled. The artificial larynx is typically held against the throat which creates sound that the member could then for into speech and use to communicate daily needs. Electronic devices create battery driven vibrations.

Speech aid devices (L8500) are reimbursed by Georgia Medicaid only if the member has had a laryngectomy or the larynx is permanently inoperative as often seen in post radical neck surgery or radiation. Since speech aid devices are considered to be augmentative and alternative communication devices (AAC), providers must obtain prior approval for these devices.

- Speech Aids must meet policy guidelines for prior approval outlined in Chapter 1101 for Augmentative and Alternative Communication Devices (AAC)
- Batteries do not require prior approval unless the total reimbursement exceeds $200.00
- ALL repairs require prior authorization

**Limitations:**

- AAC devices will be considered noncovered if all policy specific guidelines are not met.
- AAC devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one AAC device will be covered per three-five (3-5) years. If less than five (5) years, then a rationale as to the lesser lifetime must be provided.

| POLICY 1102 | Complex/Custom Rehabilitative Equipment (Rev. 04/15) |
|---|---|

Complex/custom rehabilitative equipment is covered by Georgia Medicaid for members with disabilities and chronic medical conditions (cerebral palsy, muscular dystrophy, multiple sclerosis, spinal cord injury, amyotrophic lateral sclerosis, spina bifida, birth defects, other traumatic injuries, etc.) that require specialized medical equipment to participate in the normal activities of daily living. This type of equipment is significantly different from standard durable medical equipment, and often includes items such as custom power mobility devices that require adaptive seating, positioning systems, gait trainers, specialty walkers, custom rehabilitative bathing equipment, and standing frames. Many policies require that providers employ credentialed Assistive Technology Professionals (ATP) who are certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). These professionals must specialize in assessing the appropriateness of the equipment selected and work in collaboration with the treating physician and physical or occupational therapist assessing the member.

**Supplier Requirements for Complex/Custom Rehab Equipment**

Effective September 1, 2009. Complex/Custom Rehab Suppliers must be accredited by one of the following accepted Accreditation Organizations for the service of Complex/Custom Assistive Technology:

1) The Joint Commission (TJC)
2) Commission on Accreditation of Rehabilitation Facilities (CARF)
3) Community Health Accreditation Program (CHAP)
4) Healthcare Quality Association on Accreditation (HQAA)
5) Accreditation Commission for Healthcare (ACHC)
6) American Board for Certification in Orthotics & Prosthetics, Inc. (ABC)
7) Board of Certification/Accreditation, International (BOC)

**Specialized Credential Requirements for Complex/Custom Rehab Equipment:**
Providers of Complex/Custom Rehabilitative Equipment and employees of the provider who are recommending, assessing for the use of, or repairing, modifying, or configuring seating systems or other equipment **must be registrants of NRRTS (National Registry of Rehab Technology Suppliers)**. They may refer to themselves as Rehab Technology Supplier Registrants (RTS). RTS is not a title or credential, but a description of a supplier who provides assistive technology in the area of wheeled mobility, seating and alternate positioning, ambulation assistance, environmental controls, and activities of daily living. In addition, the NRRTS registrant must be a RESNA certified ATP.

Effective January 1, 2007, Georgia Medicaid requires that all enrolled providers of Complex/Custom Rehab Equipment be or have employee(s) who are RESNA (Rehabilitation, Engineering and Assistive Technology Professional) ATP (Assistive Technology Professional) ATP certified, and who are current NRRTS registrants. There are no exceptions.

Once a registrant has been a valid NRRTS for two years, and a credentialed ATP, the individual will be considered a CRTS (Certified Rehabilitation Technology Supplier). A CRTS (Certified Rehabilitation Technology Supplier) may only be employed by one provider enrolled with Georgia Medicaid and is not permitted to work for additional providers or as a consultant or "on call" employee for multiple providers.

NOTE: NRRTS Registration is required at minimum for "Sit and Go" type power vehicles without extensive modifications. The Department is evaluating extending the requirement that providers must be NRRTS registrants and RESNA certified in order to be reimbursed for all power mobility codes. The Department recommends that providers with "NRRTS" only obtain RESNA certification.

**Providers must submit a copy of their certification for all prior authorization requests.**

Assistive Technology Review Courses Available for Fundamental Course:

1) Permobil ATP Review Course
2) University of Pittsburgh, CSUN Review Course

**Physical or Occupational Therapist (PT/OT) Requirements**

Physical or Occupational therapists are required to have a face-to-face evaluation with members requiring the use of custom or complex rehabilitative equipment. The evaluation/ detailed written order may be signed and dated by the physician to serve as the certificate of medical necessity (CMN). The PT/OT evaluation must include the license number of the therapist who performed the evaluation and made recommendations for the member. The PT/OT must have a copy of the evaluation on file in the member's record for no less than six (6) years for auditing and quality control purposes.

1) The certificate of medical necessity (CMN) for a wheelchair must be accompanied by an evaluation/detailed written order from a physical or occupational therapist for:

    - All members under twenty-one (21) years of age;
    - All members receiving a complex/custom or standard power wheelchair
    - All members receiving durable medical equipment that is complex or custom (bath chairs, gait trainers, standing frames, specialty walkers, sit-to-stand systems, etc.)
    - All members receiving a wheelchair (power or manual) with extensive modifications and seating/positioning system;

2) The PT/OT must be licensed in the State of Georgia and include the license number on the CMN.

3) The PT/OT must be enrolled in Georgia Medicaid.

4) The PT/OT must have experience with custom/complex rehabilitative technology, wheelchair and seating evaluations, and recommendations to participate in the assessment and selection of custom/complex wheeled mobility devices.

5) The PT/OT must have experience in non-mobility related assessment and recommendations to participate in the assessment and selection of all other custom or complex rehabilitative equipment (bath chairs, standing frames, specialty walkers, sit-to-stand systems, etc.).

6) The PT/OT may be associated with a school, hospital clinic or developmental center, but cannot be a supplier or be employed by a supplier or accept any reimbursement or gifts for evaluation services from a provider.

7) The PT/OT must be actively involved in the member's care and must complete the functional clinical assessment without guidance or assistance from a supplier of medical equipment. Suppliers work in collaboration with the PT/OT for information relating directly to the selection and appropriateness of the equipment required by the member (suppliers may not suggest or recommend any clinical or functional assessment information as suppliers are not clinical professionals. Physical/Occupational therapists are prohibited from supplying equipment so there should be no overlap between the clinical and technical components of the assessment).

8) The PT/OT should have the ATP/RRTS or CRTS provider present at the evaluation for complex/custom mobility evaluations to sign off on the recommendation. The ATP/RRTS or CRTS must submit a copy of their certification when submitting a prior authorization for approval of the medical equipment.

9) The signed complex/custom mobility evaluation from the PT/OT and ATP/RRTS or CRTS must be dated fewer than 180 days prior to the date of service on the request.

10) The PT/OT must submit the address and telephone number where they are employed and where they may be contacted. The PT/OT must submit their seating and positioning experience for wheeled mobility and rehab equipment.

11) Repairs for equipment requiring PT/OT evaluation must have a physician's signature and date on the detailed written order or certificate of medical necessity for the repairs.

| POLICY 1102.1 | Complex/Custom Wheeled Mobility Devices (Rev. 04/13, 07/13, 10/13, 04/15, 01/16, 4/18,10/20) |
|---|---|

When requesting power mobility devices, the physician and PT/OT must document the specific medical and physical limitations, and the daily activity level (work, school, etc.) of the member that necessitates the use of a power mobility device to complete these activities of daily living. PMDs are not covered for ambulatory members as an assistive device. The physician, PT/OT, and ATP/RRTS or CRTS (required for custom mobility, any type) must collaborate and sign and date the same assessment/detailed written order. The assessment/detailed written order may also be referred to as the certificate of medical necessity (CMN).

DME Suppliers are required to maintain all documentation in their files for medical review purposes. Every element required for the approval of the PMD (Invoice, Delivery Ticket, CMN, etc.) is considered to be part of the medical record and MUST be kept on file by the provider and available to the Department upon request for no less than six (6) years. This documentation assists in determining correct billing and coding practices for claims submitted for Medicaid reimbursement, and ensures the items reimbursed are the actual items that were delivered to the patient. The reviewing agent must be able to determine from the delivery documentation that the supplier properly coded the item(s) that the item delivered are the same item(s) submitted to Medicaid for reimbursement, and that the items are intended for, and received by a specific Medicaid beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the items are prohibited from signing or accepting the item(s) on behalf of a Medicaid beneficiary (i.e., acting as a designee on behalf of the beneficiary).

The signatures and dates on the delivery ticket MUST be complete and legible to submit for and receive reimbursement from the Medicaid program.

**Custom Wheelchairs include:**
Custom wheelchair codes include **all** codes with the exception of manual standard wheelchairs. Custom codes may include E1161, E1170, E1180, E1190, E1200, E1225, E1226, E1232, E1233, E1234, E1235, E1236, E1237, E1238, and E1240. (rev. 04/18)

**Power Wheelchair for Power Recliner:**
When requesting approval for a power wheelchair with a power recliner, the physician must document a diagnosis of quadriplegia, dwarfism, or degenerative neuro-muscular disease. The physician must include all supporting physical limitations, height, and weight of the member.

**Custom Accessories Include:**
Many of the custom accessory codes are listed in Appendix D/E (K0108), and require manual pricing; however, some are listed on the DME SMAP (if CMS provides pricing guidelines). Providers must ensure that custom/complex accessory codes such as E2607 (Low Pressure and Positioning Equalization Pad for Wheelchairs) and E2603 (Skin protection cushion) are accompanied by a PT/OT evaluation as required by policy or reimbursement guidelines.

Wheelchair Accessories

Seat and back cushions include(s) requires a prior authorization:

E2601, E2602, E2603, E2604, E2605, E2606, E2607, E2608, E2611, E2612, E2613, E2614, E2615, E2616, E2619, E2620, E2621, E2622, E2623, E2624, E2625

Other related Wheelchair Accessories:

E0950 – E0957, E0960, E0973, E0980, E0981, E0982, E0994, E0995, E1002 – E1008, E1010, E1012, E1016, E1020, E1028 – E1030 (rev. 04/18)

**Documentation Requirements for Prior Authorization:**

a) **Face-to-Face Physician Evaluation**: Members must have had an in-person evaluation with their treating physician documenting the decision to prescribe a PMD. The completion of both items 1 and 2 listed below are referred to as the face-to-face evaluation and signify that the requirements have been met. Both conditions must be met for the physician order the PMD.

   1) This evaluation must document the member's functional status and conditions affecting the member's mobility and ability to perform the normal activities of daily living, and should address the following:

      - What is the member's qualifying mobility limitations?
      - Would a cane, walker, or manual wheelchair sufficiently address the mobility limitations?
      - Does the member have the mental and physical capability to safely operate a power mobility device in the home and community?

      The following elements should also be addressed and may be included in the PT/OT evaluation portion of the Face-to Face:

      - Symptoms
      - Related diagnoses
      - History
      - How long the condition has been present
      - Clinical progression
      - Interventions that have been tried and the results
      - Past use of walker, manual wheelchair, POV, or power wheelchair (PWC) and the results
      - Physical exam
      - Beneficiary's height and weight
      - Impairment of strength, range of motion, sensation, or coordination of arms and legs
      - Presence of abnormal tone or deformity of arms, legs, or trunk
      - Neck, trunk, and pelvic posture and flexibility
      - Sitting and standing balance

- Functional assessment - any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person

2) A PT/OT evaluation signed off on by the physician

3) The record of the face-to-face examination and the order must be sent to the DME supplier within 45 days of the completion of the face-to-face examination.

b) **Specialty Evaluation-PT/OT Evaluation (face-to-face**): Suppliers must obtain a complete face-to-face wheelchair evaluation and recommendation by a Georgia licensed PT/OT for all members under the age of twenty-one (21) and all member requests for custom seating and custom wheelchairs. A RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary must be present at the seating evaluation and must sign and date the OT/PT evaluation. The Department has the right to verify credentials, therefore, a copy of eligible credentials (ATP/RRTS or CRTS) MUST be submitted during the prior authorization process for any patient evaluated for a power mobility device beginning July 2013;

Specialty Evaluations (Custom or Push rim activated PMD):

- These evaluations must be performed by a licensed/certified medical professional having specific training and experience in rehabilitative wheelchair evaluations.

- Provides detailed information explaining the need for each option and/or accessory:

  i. Power seating system
  ii. Alternate drive control interface
  iii. Push-rim activated power assist (one unit includes both rims)

c) **CMN/Detailed Written Order:**

The order must contain, at a minimum:

- Member's name
- Height & Weight
- Description of the item(s) ordered (product description is required and must sufficiently detail and identify that the item(s) ordered are the same items provided and that they were coded correctly during a retrospective review)
- Date of the completed face-to-face examination (both components completed MD/PT or OT evaluation and signed by physician)
- Qualifying diagnoses related to the need for the PMD

- Length of need
- Physician's signature (electronic or handwritten)
- Physician's NPI number
- Date of physician's signature (electronic or handwritten)
- PT/OT signature and Date (handwritten or electronic)
- PT/OT License number
- NRRTS Signature and Date (Handwritten or electronic)
- NRRTS License/Certification number
- **NRRTS must attach a copy of their certification to ALL prior authorization requests****

d) **Detailed Product Description:** The supplier should collaborate with the PT/OT and ordering physician to ensure the most appropriate power mobility device and related components and alterations are ordered based on the individual needs for the member. The detailed product descriptions on the order must include:

- Specific HCPCS codes for each item ordered
- Narrative Description of the item
- List of options and accessories that are not included in the base code

e) **Home Assessment:** Suppliers must perform and document an on-site evaluation of the member's home prior to submitting a prior authorization for approval of a power mobility device to ensure that the member's home supports the functional use of the device. This assessment must be submitted as an attachment with the prior authorization request and should document:

- Can the member adequately maneuver the device ordered considering the dimensions, physical layout, doorway width, doorway thresholds, and surfaces through the home?
- Is the home accessible by means of a ramp or elevator if not on level ground?

f) **Attestation Statement:** Power mobility devices requiring a specialty assessment require an attestation statement be submitted at the time of prior authorization indicating that there is no financial relationship between the supplier and the medical professional performing the specialty assessment.

g) **Manufacturer's Retail Quote**: **ALL** wheelchair requests (purchases, rentals, modifications, components, etc.) must include a manufacturer's retail quote. The actual wheelchair provided must contain all components listed in the retail quote and must be new equipment.

**Manually Priced Items (see appendix D/E):** for manually priced items, the quote must be provided as listed in item C, and must also include the following three components and may not be altered:

- **MSRP**
- **Primary Discount**

- **Net Cost**
- **HCPCS Code(s)**

h) **Warranty:** Suppliers must stand behind a two (2) year warranty on the major components of custom wheelchairs. The warranty must not begin until the equipment is delivered.

i) **Repairs:** A detailed written order or CMN must be signed by a physician for repairs. Suppliers must have a physical location within fifty (50) miles of the Georgia state border, and the location must have a working land line telephone and a designated repair and service department.

Suppliers providing custom wheelchairs, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, **with a technician available during normal business hours, between 8am and 6pm.** Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

**Claims Requirements**

a) Delivery must have occurred prior to the submission of a claim to the Department.

Delivery Tickets/ Pickup Tickets**:** Suppliers must keep records of the delivery or pickup of durable medical equipment on file for no less than six (6) years. The signature of the member or caregiver and the vendor, and the date must be on the document.

Proof of Delivery (Delivery Tickets) must include all of the following:

- Member's Name
- Delivery Address
- Detailed Description of Item(s) Provided (sufficient information to identify the items delivered including brand names, serial numbers, and narrative descriptions for ALL miscellaneous codes such as K0108 etc.)
- Quantities Delivered
- Date Delivered
- Member or Designee Signature and Date of Signature
- Relationship of Anyone Signing the Delivery Ticket as a Representative of the Member

b) Suppliers must list the manufacturer's name and model number in field 19 of the prior authorization or the authorization will be denied.

c) The serial number must also be entered on the claim in the appropriate field. For purchases, the serial number is entered on the initial claim, and for rentals, the

serial number is entered on the tenth (10) rental month which is the last claim submitted before the member owns the equipment.

**Limitations and Restrictions:**

- Complex/Custom wheelchairs and Power Mobility Devices are not covered for ambulatory members.

- Power wheelchairs are not covered for the convenience of the caregiver.

- Members who have recently been approved for lower limb prosthesis will not be custom/complex power or manual wheelchairs. In rare cases, a standard wheelchair may be covered.

- Used equipment and components is noncovered. Any item provided to a supplier as a “demo” is noncovered by for reimbursement by the Department. All equipment issued must be new and must have a warranty that starts at the time of initial issue.

- Suppliers may not deliver equipment that has been approved for members transitioning from nursing homes to the community until the patient has been discharged. The equipment must be delivered to the patient’s community address once the member has moved.

- Providers may not bill the Department prior to the delivery of the equipment. Audits that result in the discovery of claims submitted prior to delivery will result in recoupment.

- Procedure to Procedure NCCI Edits: Any procedure-to-procedure code combination listed on the NCCI (National Correct Coding Initiative) table will result in a denial of the column II code. This means the code in column II is included in the reimbursement of the base code or more comprehensive code listed in column I and WILL NOT be separately reimbursed. A prior authorization that contains approved codes that are listed on the NCCI table as invalid code pairs will be denied upon submission of the claim, and there are no appeal rights for these denials. Providers are responsible for reviewing these updates quarterly as they are released by CMS.

- Medically Unlikely Edits- NCCI: Any procedure submitted for units in excess of what is permitted on the MUE NCCI file will be denied. This includes any item approved on a prior authorization in excess of what is permitted by the NCCI edits. It is the responsibility of the provider to ensure they are within federal guidelines when requesting prior authorizations or submitting claims to the Department.

- Power Mobility Devices will be considered noncovered if all policy specific guidelines are not met.
- Power Mobility Devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

- Only one Power Mobility Device will be covered per three-five (3-5) years for members under 21. If less than five (5) years, then a rationale as to the lesser lifetime must be provided. Adults over twenty-one (21) are limited to one device per five (5) years.

**Reimbursement:**

Providers must refer to the Schedule of Maximum Allowable Payments (DME SMAP) for reimbursement information for items that are not manually priced. For items that are manually priced (Appendix D/E), suppliers must submit an invoice with containing MSRP, Primary Discount, and Net Cost, and this information must not be altered. The Department will not pay more than the retail price or the listed rates, whichever is lower.

Any evidence of alteration to any component of a required invoice will be referred to Program Integrity for further investigation.

| POLICY 1102.2 | Other Assistive Complex/Custom Rehabilitative Equipment |
|---|---|

Other assistive or complex/custom rehabilitative equipment requires a physician's order and, in most cases, a PT/OT evaluation and typically must be provided by a supplier of complex rehab technology (ATP/RRTS or CRTS). Providers must review the information that relates to the specific equipment for which they are requesting prior authorization and reimbursement.

| 1102.2a | SPECIALTY WALKERS<br>(REV 04/15, 07/19) |
|---|---|

Specialty walkers require a physician's order that documents the specific limitations requiring the use of the item, and a PT/OT evaluation. The supplier providing the equipment must be an ATP/RRTS or CRTS. The provider must submit a manufacturer's retail quote containing the make, model, and any serial number as an attachment to the prior authorization request. The quote serves as a confirmation of the product being requested for approval and as a method of ensuring the product supplied is coded correctly and is the same item that was approved for the member.

**Coding Guidelines:**

Specialty walkers are defined as anterior or posterior walkers that do not require external or unweighting support. Coverage is considered for members under 21-years of age.

Providers must request a prior authorization for a specialty walker using code E1399. For this item, the provider must include the MSRP, primary discount, and net cost on the invoice submitted for approval.

**E1399** - DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

| 1102.2b | SHOWER/BATH CHAIRS AND OTHER REHAB TOILET AIDS (E0240)<br>(REV10/14, 04/15, 04/18) |
|---|---|

Shower/bath chairs and other rehab toilet aids require a physician's order that documents the specific limitations requiring the use of the item, and a PT/OT evaluation. The supplier providing the equipment must be an ATP/RRTS or CRTS. The provider must submit a manufacturer's retail quote containing the make, model, and any serial number as an attachment to the prior authorization request. The quote serves as a confirmation of the product being requested for approval and as a method of ensuring the product supplied is coded correctly and is the same item that was approved for the member. For E0240-U1, the quote serves as the pricing indicator, as this modifier indicates the item is manually priced.

For this item, the provider must have the MSRP, primary discount, and net cost on the invoice submitted, and the member must be identified on the invoice by a customer invoice, etc. as this equipment is member specific and custom.

Note: Providers must submit separate PA's for more than one custom or complex item.

All items approved on a prior authorization should be submitted on the same claim, and the date of service must be the date the items were delivered. Bath/shower chairs are considered for reimbursement on professional claims only.

**Coding Guidelines:**

E0240-NU is a standard shower or bath chair which is priced from the Schedule of Maximum Allowable Payments (SMAP) for Durable Medical Equipment Services, and although it is considered complex rehab equipment, it is not custom. This item requires a standard invoice as it is not manually priced. E0240 U1 may be used to identify a custom or non-standard version of a shower/bath chair or toilet aid that requires the use of non-standard, customized equipment, and typically requires assembly prior to issue. This item requires the three (3) component invoice (MSRP, Primary Discount, and Net Cost) which is required for the approval and reimbursement of manually priced items.

**E0240** - NU BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE (OFF THE SHELF)

**E0240** - U1 BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE (CUSTOMIZED, REQUIRES COMPLEX COMPONENTS, INCLUDES ASSEMBLY)

**Limitations and Restrictions:**

**DO NOT** use E0240-U1 to submit for the prior approval or reimbursement of items that are not covered by the Department. This includes bath lifts or custom equipment for members over 21 years of age, and any item defined as noncovered in Chapter 900, Section 905. –Non-covered Services or for which there is an existing HCPCS code that is not covered by Georgia Medicaid. Beside commodes (including heavy duty, etc.) have designated HCPCS codes and should not be reported using these codes.

- These devices will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| 1102.2c | STANDING FRAME SYSTEMS (E0638) AND SIT-TO-STAND MULTI-POSITIONAL SYSTEMS (E0637) (REV. 04/15, 04/18, 10/18) |
|---|---|

A standing frame or sit-to-stand system may aid in digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcifications. Standers may be covered for members with neuromuscular conditions who are unable to stand alone. Standers are designed to support a child or adult in an upright standing position. Standing frame systems and sit-to-stand multi-positional systems require a physician's order that documents the specific limitations requiring the use of the item, and a PT/OT evaluation. Reports from the child's neurologist and/or orthopedist, as well as the GMFCS classification are also required. Requests for E0637 require an explanation be provided by the physician explaining why a single position stander (E0638) will not meet the child's medical needs.

The supplier providing the equipment must be an ATP/RRTS or CRTS. The provider must submit a manufacturer's retail quote containing the make, model, and any serial number as an attachment to the prior authorization request. The quote serves as a confirmation of the product being requested for approval and as a method of ensuring the product supplied is coded correctly and is the same item that was approved for the member.

**Coverage Guidelines:**

Standing Frames and Sit-to-Stand Systems require (coverage considered for members under 21 years of age): (rev. 04/18)

a) The member is unable to stand or ambulate independently
b) The member is a high risk for lower-limb or trunk contractures
c) The alignment of the members feet and ankles can tolerate standing in an upright position (Standing frame)
d) The member does not have complete paralysis of the hips and legs
e) The member has had improvement in mobility, ambulation, function, or physiological symptoms with the use of the selected device;
f) The member has a neuromuscular or congenital disorder, including acquired skeletal disorders;
g) The member is able to utilize the equipment without being medically or functionally compromised;
h) The member has a plan of care documenting how the system will be used in the home and/or community setting;
i) The documentation addresses least costly alternatives, including items that have been tried and failed prior to the recommendation for the ordered equipment;
j) The equipment must accommodate growth and adjustments for seating systems at a minimum of 3" in depth and 2" in width (for pediatrics)

**Coding Guidelines:**

Providers must request prior authorization for the code that most accurately describes the product ordered by the physician in collaboration with a physical or occupational therapist.

**E0637 -** COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS

**E0638 -** STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS

**E0621 -** SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON (REPLACEMENT ONLY)

**Reimbursement:**

Effective June 1, 2014, Stander codes, E0637 (Combination sit to stand system, any size including pediatric, with sealift feature, with or without wheels) and E0638

(Standing frame system, one position (e.g., upright, supine, or prone stander, any size including pediatric, with or without wheels) must be submitted with a manufacturer's invoice that contains the MSRP and the provider's cost for the base code and all accessories/modifications a Stander must be reported with 1 unit of service and modifier NU, which will include all modifications/components, and will be manually priced at a rate of 40% above the supplier's cost up to the Medicaid maximum allowable amount. The prior authorization will include one approved purchase price that will be all inclusive (base code and all options/accessories that are approved). Standers are covered once per 3-5 years on a case-by-case basis.

The stander/sit-to-stand (all inclusive) (E0637 or E0638) should be submitted on Line 1 of the claim with an "NU" modifier. All additional accessories or modifications that may be included on the manufacturer's invoice are listed below.

Example:
Line 1 – E0637 NU – (Number of Units Billed- 1) – (Submitted charge 40% above provider's cost).

The items listed here are the maximum units allowed per invoice, per system. These items are reported as one unit with one combined rate as approved on the prior authorization.

| DESCRIPTION | Items allowed on invoice: |
|---|---|
| BASE SYSTEM | 1 |
| BACK SUPPORT OR HIGH/EXTENDED BACK SUPPORT | 1 |
| LATERAL HIP SUPPORTS OR LATERAL THORACIC SUPPORTS | 2 |
| SUPPORT ACCESSORY / MOUNTING HARDWARE | 1 |
| ABDUCTION PAD / PUMMEL OR MEDIAL THIGH SUPPORT | 2 |
| ANTERIOR CHEST VEST, CHEST STRAP, OR PAD | 1 |
| ANTERIOR AND / OR POSTERIOR INDEPENDENT KNEE SUPPORT | 2 |
| ANTERIOR / POSTERIOR HEAD SUPPORT | 1 |
| PELVIC SUPPORT BELT | 1 |
| TRAY/UPPER EXTREMITY SUPPORT | 1 |
| ANKLE/FOOT SUPPORT | 2 |

**Limitations:**

These devices will not be considered medically necessary if any of the following applies:

- There is insufficient evidence-based medical benefit to using the device (when there is no expected improvement in mobility or maintenance of function).
- The anticipated functional benefits of standing can be achieved through a least costly alternative (therapeutic exercises, positioning, orthotics, other adaptive DME, medication, or diet)
- These devices will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

- Only one device will be covered per three-five (3-5) years. If less than five (5) years, then a rationale as to the lesser lifetime must be provided.

| 1102.2d | Gait Trainers (E8000, E8001, E8002)<br>(Rev. 04/18) |
|---|---|

A gait trainer is a wheeled device that is designed to provide support to members with lower-limb and trunk weakness that are capable of standing in an upright position to allow reciprocal movement of the lower extremities which allows the member to walk with assistance. Gait trainers often allow members who would otherwise be wheelchair bound to ambulate. Gait trainers are approved on a case-by-case basis, through the prior authorization process.

Gait trainers require a physician's order that documents the specific limitations requiring the use of the item, and a PT/OT evaluation. The supplier providing the equipment must be an ATP/RRTS or CRTS. The provider must submit a manufacturer's retail quote containing the make, model, and any serial number as an attachment to the prior authorization request. The quote serves as a confirmation of the product being requested for approval and as a method of ensuring the product supplied is coded correctly and is the same item that was approved for the member.

Gait trainers require (coverage considered for members under 21 years of age): (rev. 04/18)

a) The member is able to stand upright assistance and has sufficient lower-limb and truck strength to be able to functionally use the device;
b) The member is unable to ambulate safely without the device due to conditions relating to, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities;
c) The member does not have lower limb contractures or complete paralysis of the hips or legs;
d) The member has adequate range of motion to support ambulation;
e) The alignment of the member's feet and ankles can tolerate standing in an upright position;
f) The member has shown improvement in mobility, ambulation, function, or physiological symptoms or maintained functional status due to the use of the selected gait trainer, and is able to follow the home therapy program which incorporates the use of the gait trainer;
g) There is a written home therapy plan outlining the use of the requested gait trainer.

**Coding Guidelines:**

Providers must request prior authorization for the code that most accurately describes the product ordered by the physician in collaboration with a physical or occupational therapist.

**E8000** - GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS

**E8001** - GAIT TRAINER, PEDIATRIC SIZE, UPRIGHT SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS

**E8002** - GAIT TRAINER, PEDIATRIC SIZE, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS

**Limitations:**

These devices will not be considered medically necessary if any of the following applies:

- There is no expected improvement in mobility or maintenance of function;
- The anticipated functional benefits of a gait trainer can be achieved through least costly alternatives;
- Equipment is not medical in nature (gliders)
- These devices will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per three-five (3-5) years. If less than five (5) years, then a rationale as to the lesser lifetime must be provided.

| 1102.2e | Patient Lifts<br>(Rev. 04/15) |
|---|---|

A patient lift is a device that is hydraulic or motorized (electronic) that enables a member to transfer from the bed to a chair or other sitting device, or vice versa. These lift mechanisms assist members with varying abnormalities that prevent them from being able change positions (in a bed to a seating position) or transfer without assistance.

**Coverage Guidelines:**

A patient lift (E0630, E0635) is covered if the following criteria are met:

a) A physician orders the device for safe transfers that are required between a bed and a chair, wheelchair, or commode and, without the use of a lift; the member would be confined to a bed.

A multi-positional patient transfer system (E1035) is covered if both of the following criteria are met:

a) A physician orders the device for safe transfers that are required between a bed and a chair, wheelchair, or commode and, without the use of a lift; the member would be confined to a bed.
b) The member requires supine positioning for transfers

**Coding Guidelines:**

Suppliers must request a prior authorization, which includes a PT/OT evaluation, for a patient lift to be considered for coverage. Patient lifts are only reimbursed as a monthly rental and will cap after ten (10) rental months have been reimbursed and will then be considered to be member owned.

**E0630 -** PATIENT LIFT, HYDRAULIC OR MECHANICAL, INCLUDES ANY SEAT, SLING, STRAP(S) OR PAD(S)

**E0635** - PATIENT LIFT, ELECTRIC WITH SEAT OR SLING

**E1035** - MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS

**Replacement Only:**

**E0621 -** SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON (REPLACEMENT ONLY)

Slings are not separately reimbursed with the purchase of a patient lift and will only be covered as a replacement once per twelve (12) months if necessary, beginning no sooner than twelve (12) months from the initial date of service (first rental month or purchase date).

**Limitations:**

- Only one (1) type of device will be covered during the reasonable useful lifetime of the equipment.
- Slings will be denied if billed prior to the member owning the base equipment for one year.
- Slings will not be replaced sooner than once (1), per twelve (12) months.
- Patient lifts will be denied if they are submitted for reimbursement without an approved prior authorization.
- These devices will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1103 | Standard Manual Wheelchairs and Other Considerations (Rev. 04/15) |
|---|---|

Manual wheelchairs are mobility devices that assist in the completion of the normal activities of daily living when a member is unable to ambulate safely and effectively. Mobility impairments include a wide range of disabilities that affect the ability to move independently and cause limited mobility. These impairments are often associated with paralysis, muscle weakness, nerve damage, stiffness in joints, and balance and coordination deficits.

Manual wheelchairs require a physician's order that documents the specific limitations that support the medical necessity for the device, and the ambulatory status. If a member has had a stroke, the physician must document the date of the stroke and expected rehabilitation potential. For members under the age of twenty-one (21), there must also be a face-to-face evaluation with a physical or occupation therapist who is actively involved in the child's care. This assessment must include a recommendation for the appropriate wheelchair, and must be reviewed, signed, and dated by the physician.

Providers that do not supply Custom/Complex Rehab equipment may provide standard wheelchairs for members who meet the coverage criteria for the device only when the request is for a short-term rental or for situations that do not require a PT/OT evaluation (e.g., no weight bearing capabilities). Standard wheelchair codes include: E1130, E1140, E1150, and E1160. Standard heavy-duty wheelchairs include: E1280 and E1209. Standard heavy-duty wheelchairs include seat dimensions up to 24" wide and 18" deep and can functionally support a member who weights up to 350lbs. Members who weigh more than 350lbs must be evaluated by a PT/OT at a seating clinic and equipment must be provided by a supplier of complex/custom rehab equipment.

Manual wheelchairs are approved on a case-by-case basis through the prior authorization process. The specific device requested will be approved or denied based on the member's impairments, level of function, medical condition, activity level, and seating and positioning needs. The device requested must be the most appropriate and least costly alternative that meets the functional ambulatory needs of the member. The member's height and weight must be included on the detailed written order/CMN for approval.

**Other Coverage Guidelines:**

Providers must request prior authorization for the code that most accurately describes the product ordered by the physician in collaboration with a physical or occupational therapist. For a listing of covered codes, please refer to the schedule of maximum allowable payments for DME services (DME SMAP).

**Travel Wheelchairs**

Only standard wheelchairs with fixed arms will be allowed as travel wheelchairs for members with power mobility devices, and only when the member's power wheelchair cannot be folded to fit inside the member or caregiver's vehicle. Separate

documentation must be submitted requesting the short-term (1-3 month) rental of the device. The physician's order and PT/OT evaluation for members less than twenty-one (21) years of age must accompany the prior authorization request. The length of need must correspond to the travel dates and must be documented.

Stroller type transporters (Pogon, Hogg, McClaren, etc.) are only reimbursed for children under the age of two (2) unless the ordering physician specifically requests this type of equipment for a member over the age of two (2) and provides a detailed rationale of the medical necessity and basis for the selection of the device.

**Backup Wheelchairs**

Backup equipment is not separately reimbursed by the Department as it is considered "same or similar" equipment; however, the supplier must provider a loaner wheelchair to members during periods of time when they are being reimbursed for another service for the member's existing wheelchair (active rental period, service, or maintenance, etc.).

**Youth Wheelchairs, any Type**

All wheelchairs for members under the age of twenty-one (21), require a face-to-face evaluation with a physical and an assessment performed by a physical or occupation therapist who is actively involved in the child's care. This assessment must include a recommendation for the appropriate wheelchair based on the functional needs of the member, and must be reviewed, signed, and dated by the physician. Refer to the PT/OT requirements listed in Chapter 1102 for specific criteria required by the physical or occupational therapist performing these assessments.

**Coding Guidelines:**

Refer to the Schedule of Maximum Allowable Payments for Durable Medical Equipment Services and/or Appendix D for a comprehensive listing of covered wheelchairs.

**Limitations:**

These devices will not be considered medically necessary if any of the following applies:

- The device ordered exceeds the basic requirements for the individual's condition or mobility needs);
- HCPCS codes submitted for approval with weight parameters (heavy duty, light weight, pediatric) that do not align with height, weight, and/or measurements documenting the medical necessity;
- The anticipated functional benefits of the wheelchair can be achieved through least costly alternatives (walker, cane, etc.)
- These devices will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule Maximum Allowed Payments (SMAP) or the reasonable useful lifetime table located in section 910.

| POLICY 1104 | Diabetes Management (Rev. 04/15) |
|---|---|

According to the World Health Organization (WHO), diabetes is a chronic disease that occurs when the pancreas does not produce sufficient amounts of insulin or when the body does not effectively use the insulin produced. Hyperglycemia (high blood sugar) is a common effect of uncontrolled diabetes, and if left untreated, may lead to serious damage to many of the body's systems. Georgia Medicaid covers CGM (continuous glucose monitors) and insulin infusion pumps through the DME program, and glucose monitors and supplies though the pharmacy program.

### *Type 1 diabetes*

Type 1 diabetes (previously known as insulin-dependent, juvenile or childhood-onset) is characterized by deficient insulin production and requires daily administration of insulin. The cause of type 1 diabetes is not known, and it is not preventable with current knowledge.

Symptoms include excessive excretion of urine (polyuria), thirst (polydipsia), constant hunger, weight loss, vision changes and fatigue. These symptoms may occur suddenly.

### *Type 2 diabetes*

Type 2 diabetes (formerly called non-insulin-dependent or adult-onset) results from the body's ineffective use of insulin. Type 2 diabetes comprises 90% of people with diabetes around the world (5) and is largely the result of excess body weight and physical inactivity.

Symptoms may be similar to those of Type 1 diabetes but are often less marked. As a result, the disease may be diagnosed several years after onset once complications have already arisen.

Until recently, this type of diabetes was seen only in adults, but it is now also occurring in children.

### *Gestational diabetes*

Gestational diabetes is hyperglycemia with blood glucose values above normal but below those diagnosed with diabetes, occurring during pregnancy. Women with gestational diabetes are at an increased risk of complications during pregnancy and at delivery. They are also at increased risk of type 2 diabetes in the future.

Gestational diabetes is diagnosed through prenatal screening, rather than reported symptoms.

| POLICY 1104.1 | Continuous Glucose Monitor (Implemented 01/15, Rev. 04/15, 04/18, 07/19) |
|---|---|

A Continuous Glucose Monitoring System (CGM) is a device with three components (transmitter, receiver, and sensors) used by placement of a sensor, subcutaneously, to continuously monitor and record glucose levels obtained from interstitial fluid. Real-time readings allow the member to monitor alerts indicating glucose issues and take immediate corrective action. This device does not replace finger stick readings.

A CGM ordered for in-home use requires prior authorization and must be prescribed by the **endocrinologist** who is treating the condition for which the device is ordered. Short-term use of CGM is not covered through the DME program as it is part of a clinical service. Long-term usage (>30 days) requires the submission of a prior approval for the purchase of the transmitter and receiver and the appropriate number of refills for supplies (sensors).

Alternatively, a therapeutic continuous glucose monitoring device is indicated for replacing blood glucose testing, detecting trends, tracking patterns aiding in the detection of episodes of hyperglycemia and hypoglycemia, and facilitating both acute and long-term therapy adjustments in persons diagnosed with diabetes.

**Coverage will be considered for members under 21 years of age (or on a case-by-case basis for members over 21) if the member currently has a diagnosis of uncontrolled Type I DM or Type II DM requiring 3 or more injections of insulin per day AND one of the following indication(s):**

- Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
- Hypoglycemic unawareness: patient is not aware of symptom, but it may be witnessed by others
- Poor glycemic control despite at least 4 finger-sticks per day
- Hypoglycemia overnight
- Recurring diabetic ketoacidosis (DKA)
- Specific indications will be considered on a case-by-case basis when appropriate
- Insulin pump usage with poor control
- Specific cases where CGM use led to improvement in control and the clinician feels that prolonged monitoring is needed for an insulin dependent diabetic under 21-years of age

CGMs for any other indication are considered **not medically necessary** because effectiveness has not been established.

Coverage on a case-by-case basis for members over 21-years of age will attribute to supply coverage for members that received the initial CGM device while meeting the medical policy requirement.

**New requests for members over 18-years of age that meet medical necessity must be prescribed a therapeutic glucose monitoring device (K0554) and supplies (K0553).**

The continuous glucose monitoring system, which includes all internal and external components (A9276) will be considered for coverage of the glucose sensor, (A9277) will be considered for the coverage of the transmitter, and (A9278) will be considered for the coverage of the external monitor to view your glucose levels, also known as the receiver.

Therapeutic CGM devices may consist of various components such as a sensor, a transmitter, and a receiver. The glucose sensor generates a small electrical signal in response to the amount of interstitial glucose detected. This electrical signal is converted into a glucose reading that is then sent to the transmitter. The transmitter sends the measurements wirelessly to a dedicated receiver (or type of monitor) and/or compatible mobile device (smart phone, tablet, etc.) for display to the user. The receiver displays the glucose measurements in the form of a graph so that the glucose measurements can be visualized. All components will be considered for coverage with a prescription order and an approved prior authorization. The following codes will be considered for coverage, (K0554) for the receiver/monitor and (K0553) for the monthly supply allowance of the therapeutic CGM.

**CGM is noncovered for:**

- Short-term use
- Items ordered for convenience

**Required Documentation:**

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested services in the letter of medical necessity, a prescription order by the referring physician for the specific CGM device to be supplied to the member, number sensors requested per month, and length of need. Medical records and chart notes must document the member has been diagnosed with diabetes and that the member has received and has sufficient training using the requested device.

Note**:** The medical records documentation must include 30-days' worth of glucose data collected within 6-months of the written ordered date.

**Coding Guidelines:**

Suppliers must request a prior authorization for all components of the CGM and related supplies. A certificate of medical necessity must be submitted with the request.

**A9276** - SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

**A9277** - TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

**A9278** - RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

**K0553** - SUPPLY ALLOWANCE FOR THERAPEUTIC CONTINUOUS GLUCOSE MONITOR (CGM), INCLUDES ALL SUPPLIES AND ACCESSORIES

**K0554** - RECEIVER (MONITOR), DEDICATED, FOR USE WITH THERAPEUTIC CONTINUOUS GLUCOSE MONITOR SYSTEM

**Limitations:**

- Components of a continuous glucose monitor will be noncovered if billed in excess of the maximum allowed on the SMAP (exception transmitters may be reviewed for medical necessity and replaced from six (6) to twelve (12 months) but must have a detailed rationale for the need if less than twelve (12) months has elapsed since the last transmitter was issued.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1104.2 | Home Blood Glucose Monitor and Supplies (Rev. 11/11) |
|---|---|

**Durable Medical Equipment (DME) Diabetic Supplies Transition to Pharmacy**

**Effective November 1, 2011**, The Georgia Department of Community Health (DCH) transitioned the following Durable Medical Equipment (DME) diabetic supplies: insulin syringes, pen needles, lancing device, lancets, blood glucose monitoring strips, and blood glucose monitors to the Georgia Medicaid Fee-For-Service (FFS) Outpatient Pharmacy Program.

The following supplies are no longer reimbursable under the DME Program Category of Service (COS) 320:

**DME SUPPLY CODE**

- **A4259** - LANCETS, PER BOX OF 100
- **A4253** - BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS
- **E2100** - BLOOD GLUCOSE MONITOR WITH INTEGRATED VOICE SYNTHESIZER

Only the insulin infusion pump (E0784) and its supplies (A4230, A4231, A4232, K0101, K0602, K0603 and K0604) continue to be reimbursed under the DME program. This does not affect the transmission of crossover claims. Crossover claims will process as usual.

Diabetic supplies are only available through enrolled Georgia Medicaid FFS Outpatient Pharmacies when prescribed by a physician. Georgia licensed pharmacies, when enrolled, are simultaneously assigned to COS 300 and 321. Only providers eligible to enroll in COS 300 and 321 are eligible to dispense approved FFS insulin syringes, pen

needles, lancing device, lancets, blood glucose monitoring strips, and blood glucose monitors to non-nursing home Medicaid PeachCare diabetic patients.

Claims submitted by pharmacies for FFS members are processed by the Pharmacy Benefit Manager (PBM), OptumRx, Inc. (COS 300), except for blood glucose monitors which are processed directly through the manufacturer. All claims (including blood glucose monitors) submitted by pharmacies for crossover members (dual eligible) are processed by Hewlett Packard (HP) Enterprises Services through the Medicaid Management Information System (MMIS) (COS 321). Only dual eligible members are eligible to continue to receive services from DME suppliers.

| POLICY 1104.3 | Disposable Insulin Management System (Imp. 01/21) |
|---|---|

Georgia Medicaid considers a disposable external insulin delivery system as an acceptable alternative to a standard insulin infusion pump for persons who are under the age of 21-years that meet medical necessity as defined.

## Omnipod® System

The Omnipod® system is a two-part insulin delivery system. The first part consists of a disposable Pod, which attaches to the members body with adhesive and delivers insulin through a small needle or cannula for up to 72 hours. The second part is the Personal Diabetes Manager (PDM) which is portable and programmable, and sends dosing instructions to the pod, records data, and can be used to test blood glucose levels. Since the PDM communicates wirelessly to an insulin reservoir that contains up to 72 hours of insulin, there are no wires or tubes.

### Coverage Guidelines:

The Omnipod® System will be considered for coverage when the following requirements are met and clearly documented in the patient's medical record.

1. The member is under the age of twenty-one (21) years; AND
2. The member has a diagnosis of insulin dependent type 1 diabetes mellitus; AND
3. The treating endocrinologist or physician who is experienced in providing insulin therapy services attests that he/she will monitor the members status while the device is used; AND
4. The physician documents a history of poor glycemic control on multiple daily injections of insulin, including a persistently elevated glycosylated hemoglobin level (HBA1C > 7.0%); AND
5. The physician documents additional history of poor control, such as:
    a) Injection of insulin 3 or more times per day;
    b) More than 3 adjustments of daily dosage over the previous 6 months;
    c) Testing of sugar at least 4 times a day for the previous 2 months;
    d) One documentation in the record of a fasting C-peptide level less than or equal to 110% of the lower limits of the normal range for the testing

laboratory range or less than or equal to 200% of the lower limits of the normal range for individuals with a creatinine clearance of <50; AND

e) At least one of the following should also be present:
    i. Glycosylated Hemoglobin level over 7%
    ii. History of Hypoglycemia (less than 55) on more than 4 occasions in previous 4 weeks
    iii. Wide fluctuations in blood glucose levels prior to mealtime
    iv. Dawn phenomenon with fasting blood sugars over 200mg/DL on more than 3 times a week for 4 weeks

6. The member/caregiver has demonstrated the ability and commitment to comply with the PDM device management and Pod replacements, frequent self-monitoring of blood glucose, and careful attention to diet and exercise, and has received appropriate training on usage of the device and delivery system.

**Coding Guidelines:**

**A9274** - EXTERNAL AMBULATORY INSULIN DELIVERY SYSTEM, DISPOSABLE, EACH, INCLUDES ALL SUPPLIES AND ACCESSORIES (Omnipod® Pods)

**E0607 U1 -** BLOOD GLUCOSE MONITOR HOME (Omnipod® PDM Only)

Note: 1 Personal Diabetes Manager device will be covered every 4 years; and up to 15 pods per 30 days when additional documentation is provided which supports the medical necessity for more than 10 pods per month.

**Limitations:**

- Noncovered for members over twenty-one (21) years of age.
- Members who do not have a diagnosis of Insulin Dependent Type 1 or Gestational (insulin dependent) diabetes will not be covered.
- Units in excess of what is allowed on the SMAP will be denied.
- Device will not be replaced prior to the end of the reasonable useful lifetime of the equipment.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1105 | Home Phototherapy (Rev. 04/13, 07/13, 10/14) |
|---|---|

Home phototherapy is covered for members diagnosed with neonatal jaundice (hyperbilirubinemia) for use within the first thirty (30) days of life. The physician is responsible for assessing the appropriateness of home phototherapy for each day of use. The physician determines each treatment and the length of time the infant is to be under the lights based on the serum bilirubin levels and the clinical condition of the infant. There must be a separate detailed written order and bilirubin level for each treatment.

Any FDA approved home phototherapy system, as prescribed, may be used. The maximum fee is a daily rate that is all inclusive of equipment, related supplies, and a certified nurse or technician to collect a daily bilirubin level. The bilirubin may be obtained by a certified lab. Home phototherapy is covered for a maximum of five (5) consecutive days and includes all related services (equipment rental, nursing services, blood draw, supplies, and other services, per diem). Prior authorization is not required, and no modifier should be reported. The provider must keep the daily prescription and bilirubin levels on file.

Home visits and associated professional services must be performed by a current licensed registered nurse or a person currently certified to perform the related services (i.e., certified laboratory technician). A skilled nursing visit may not be billed in the Home Health program for this service. The DME provider must assure that the parent or caregiver has been trained on the safe and effective use of the home phototherapy equipment.

The Department does not reimburse for home phototherapy until the member is discharged from the hospital.

Phototherapy services may not be billed through the Durable Medical Equipment program when provided for use of a patient who is currently receiving Home Health Services. The home health agency must assure that the parent or caregiver is trained in the safe and effective use of the home phototherapy equipment and guidelines for home health reimbursement must be followed. Refer to the Part II Manual for Policies and Procedures for Home Health Services.

**Coverage Guidelines:**

Home phototherapy devices for neonatal hyperbilirubinemia (774.0-774.7) are considered medically necessary when all of the following criteria are met**:**

- Bilirubin level at initiation of phototherapy (at least 48 hours of age) is 14-18 mgs per deciliter; **and**; -
- The treating physician ordered home phototherapy services for up to five (5) consecutive days;
- Arrangements have been made to evaluate the infant each day of in-home use of phototherapy services to ensure it is effective and remains medically necessary for the duration of use;

- The infant has been discharged from the hospital and is at least 48 hours old; **and**
- The infant is otherwise healthy, eating well, and active**; and**
- The caregiver(s) is compliant and provides a safe environment; **and**
- Follow-up evaluations are completed by the physician in the office or by nursing visits in the home; **and**
- Phototherapy equipment is used in the home, such as a lamp, light panel, fiber optic blanket or band and is provided by a durable medical equipment (DME) provider.

**Coding Guidelines:**

Phototherapy does not require prior authorization; however, the provider must have all required documentation on file. Do not report E0202 with rental modifier (RR) as all rentals require prior authorization, per DCH policy.

**E0202 -** PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER

**Limitations:**

- No more than 5 units may be billed per lifetime
- Therapy may not occur before the infant is 48 hours old and discharged to the home
- Therapy may not occur after the infant is 30 days old
- If the infant is receiving home health services phototherapy may not be billed through the DME program
- These devices will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule Maximum Allowed Payments (SMAP).

| POLICY 1106 | Hospital Beds and Accessories (Rev. 04/13, 04/15) |
|---|---|

Hospital beds for in-home use are a special type of furniture designed to assist in the therapeutic treatment of known medical conditions that require positioning and elevation that is not available in ordinary beds. These hospital beds come in a variety of designs and have many options and accessories available to assist and protect members. Hospital beds provide many features such as height adjustments and head and leg elevation. Hospital beds are often appropriate for members with congestive heart failure.

a) A **fixed height hospital bed** is one with manual head and leg elevation adjustments but no height adjustment.
b) A **variable height hospital bed** is one with manual height adjustment and with manual head and leg elevation adjustments.
c) A **semi-electric hospital bed** is one with manual height adjustment and with electric head and leg elevation adjustments.
d) A **total electric hospital bed** is one with electric height adjustment and with electric head and leg elevation adjustments.
e) A **heavy-duty hospital bed** is one that supports a member who weights 350lbs-600lbs.
f) An **extra heavy-duty hospital bed** is one that supports a member who weighs more than 600lbs.

**Coverage Guidelines:**

Hospital beds are not approved for ambulatory members. The bed bound status of the member must be described in detail. When requesting prior authorization for hospital beds, documentation must include the elevation and positioning requirements that cannot be met by use of an ordinary bed. The documentation must also indicate that the member or caretaker can perform the necessary changes in elevation and body positioning only by use of electronic controls if this option is requested.

Requests for bariatric beds for members who are morbidly obese must include information regarding weight management and document the member's weight at time of order. Members requesting bariatric beds must also meet the standard criteria for a hospital bed to be covered. A hospital bed will not be approved for morbid obesity alone. **The manufacturer's name and model must be on the PA, or the PA will be denied.**

Hospital beds must accommodate the physical characteristics of the member. The warranty must cover the height and weight of the member and allow for some weight increase. This should include an allowance of up to an additional 100 pounds for bariatric members.

**Hospital beds and Accessories are covered if one or more of the following criteria are met and prior approval has been granted:**

- The member requires positioning of the body in a way that cannot be achieved through the use or a standard bed due to a medical condition that requires

positioning to alleviate pain, prevent contractures, or avoid respiratory infections;
- The member requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration;
- The member requires special attachments or traction equipment that can only be attached to a hospital bed;
- The member's weight is documented and appropriate for the hospital bed ordered:

  All of the following criteria must also be met and documented:

  1) The percentage of time the member is bed bound
  2) The percentage of time the member is left unattended
  3) The primary caregiver must be identified as well as the ability of the caregiver to perform the required positioning and elevation of the member
  4) Decubitus ulcer status (none or the stage and location If applicable)
  5) The height and weight of the member
  6) All diagnoses supporting the order for the hospital bed and accessories
  7) A detailed description of all items ordered

**Coding Guidelines:**

Suppliers must request a prior authorization for a hospital bed to be considered for coverage.

**E0255** - HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

**E0260** - HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS

**E0261** - HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

**E0265** - HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS

**E0271** - MATTRESS, INNERSPRING

**E0301** - HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

**E0302** - HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

**E0303** - HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

**E0304** - HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

**E0310** - BED SIDE RAILS, FULL LENGTH

**E0315** - BED ACCESSORY: BOARD, TABLE, OR SUPPORT DEVICE, ANY TYPE

**E0910** - TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR

**E0912** - TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR

**E0940** - TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR

**Limitations:**

- Noncovered for ambulatory members
- Hospital beds will not be approved for use as cribs or as a convenience item for the member or caregiver who could reasonably use an ordinary bed without adversely affecting any related medical conditions.
- Hospital beds cannot be approved for safety or convenience reasons only
- Diagnoses of Arteriosclerotic Heart Disease, Angina, Congestive Heart Failure or other general cardiac conditions, morbid obesity, epilepsy, or mental retardation do not in and of themselves justify the medical necessity of purchasing or renting hospital beds
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule Maximum Allowed Payments (SMAP).

| POLICY 1106.1 | Enclosed Pediatric Beds or Canopy (Implemented 04/15) |
|---|---|

Specialized (enclosed) pediatric hospital beds or a canopy attachment for a standard hospital bed are rarely medically necessary and will be approved on a case-by-case basis through the prior authorization process for members less than 21 years of age.

a) An enclosed pediatric manual hospital bed is one with a full side rail (360 degrees up to 24 inches high) enclosure.
**b)** A hospital bed safety enclosure frame/canopy features fully enclosed sides and a top that is attached to a hospital bed.

**Coverage Guidelines:**

E0328 or E0316 will be considered for coverage if all the following criteria are met:

1) The member has a diagnosis-related cognitive or communication impairment or a severe behavioral disorder that results in a safety risk if placed in a standard hospital bed;
2) There member is mobile and at risk of entanglement in a standard hospital bed or travelling outside of the home;
3) Least costly alternatives have been tried and failed;
4) The request is not based on physical or environmental issues such as hunger, thirst, pain, restlessness, use of restroom, changes in caregivers or routines, etc.
5) For members with severe behavioral disorders, there is a plan for behavioral management
6) A written plan for monitoring the member has been approved by the ordering physician describing when the bed will be used, how the member will be monitored, how all the member's needs will be met while enclosed in the bed (toileting, eating, hydration, skin care and general safety), and an explanation of how any documented medical conditions (e.g., Seizures) will be managed while the bed is in use.

**Coding Guidelines:**

Suppliers must request a prior authorization for a pediatric hospital bed or canopy to be considered for coverage. These items may be rented for short-term use but will be considered capped once ten (10) rentals have been reimbursed.

**E0316 NU or RR** - SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE (*EXCLUDING SPECIALITY- SEE E0316 U1)*

**E0316 U1** - SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE; NOAH TYPE SAFETY ENCLOSURE (INVOICE REQUIRED FOR PRICING NOT TO EXCEED $5270.40)

**E0328 NU or RR** - HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS (*EXCLUDING SPECIALTY- SEE E0328-U1)*

**E0328 U1**- HOSPITAL BED, PEDIATRIC, HI-LO ELECTRIC, ADJUSTABLE HEAD, KNEE, AND MATTRESS HEIGHT, INCLUDES SPRING, MATTRESS, CASTERS, AND FOAM RAIL COVERINGS (4 SIDES); SLEEP SAFE TYPE BED (INVOICE REQUIRED FOR PRICING NOT TO EXCEED $8581.60 COMBINED TOTAL)

**Reimbursement Guidelines:**

E0316 NU - Refer to the DME Schedule of Maximum Allowable Payments for pricing information.

E0328 NU - Refer to the DME Schedule of Maximum Allowable Payments for pricing information.

E0316 U1 - requires manual pricing and will be limited to the lesser of the MSRP invoice price or the maximum allowed $5270.40.

E0328 U1 - requires manual pricing and will be limited to the lesser of the MSRP invoice price or the combined maximum allowed $8581.60 (Complete Bed $7735.20 and 4 side high density foam cover 846.40). If only one component is provided, then the provider will be reimbursed for only that component.

**Limitations:**

- Enclosed beds/canopy are not covered for use as infant cribs or as a convenience item
- Enclosed beds/canopy beds are not covered for members over 21 years of age
- Enclosed beds/canopy submitted under a miscellaneous code is not covered
- May only be replaced once per 3 years (member must have had significant growth during the 3 years of use)
- These devices and accessories will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1107 | Inexpensive/ Routinely Purchased Equipment (Rev. 04/15) |
|---|---|

Inexpensive durable medical equipment is a device that is relatively inexpensive, typically does not require prior approval, and is most often purchased by the Department. These items are only eligible for replacement after the reasonable useful lifetime of any previously purchased item that is considered to be “same or similar” has expired.

In limited cases or in instances where the purchase price exceeds $200.00, a prior authorization may be required as indicated on the Schedule of Maximum Allowable Payments. Items submitted to the Department as a request for a rental period will be subject to prior approval.

Reimbursement of inexpensive / routinely purchased items is subject to post-pay review. The member’s record must contain a minimum of the following for all items in this policy:

- Physician’s order for the actual device provided.
- Proof of delivery with the member or caregiver’s signature and date
- Evidence of a face-to-face evaluation within the six (6) months preceding the written order.

| POLICY 1107.1 | Commode Chairs/ Raised Toilet Seat (Rev. 04/15) |
|---|---|

**Coverage Guidelines:**

A commode chair or raised toilet seat will be considered for coverage for members who meet one of the following criteria:

1) The member is confined to a single room, or
2) The member is confined to one level of the home where there is no toilet; or
3) The member is confined to a home where there are no toilet facilities

A commode chair with detachable arms (E0165) is covered for a member who weighs 300 pounds or more.

**Coding Guidelines:**

These items do not require prior approval for determination of coverage.

**E0163** - COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS

**E0165** - COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS

**E0167** - PAIL OR PAN FOR USE WITH COMMODE CHAIR, REPLACEMENT ONLY

**E0244** - RAISED TOILET SEAT

**Limitations:**

- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule Maximum Allowed Payments (SMAP).

| POLICY 1107.2 | Canes and Crutches (Rev. 04/15) |
|---|---|

**Reimbursement Guidelines:**

A cane or crutches will be considered for coverage if all the following criteria (1-3) are met:

1) The member has a mobility limitation that significantly impairs the ability to participate in one or more mobility- related activities of daily living.

   A mobility limitation is one that:
   - Prevents the member from accomplishing a mobility related activity of daily living entirely; or,
   - Places the member at reasonable risk of morbidity or mortality secondary to the attempts to perform an activity of daily living; or
   - Prevents the member from completing activities of daily living within a reasonable time frame

2) The member is able to use the cane or crutches safely and effectively.

3) The functional mobility deficit can be sufficiently resolved by use of a cane or crutches.

**Coding Guidelines:**

These items do not require prior approval for determination of coverage.

**A4635** - UNDERARM PAD, CRUTCH, REPLACEMENT, EACH

**A4636** - REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH

**A4637** - REPLACEMENT, TIP, CANE, CRUTCH, WALKER, EACH

**E0100** - CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP

**E0105** - CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS

**E0111** - CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HANDGRIPS

**E0113** - CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP

**E0116** - CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, WITH PAD, TIP, HANDGRIP, WITH OR WITHOUT SHOCK ABSORBER, EACH

**E0153 -** PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH

**Limitations:**

- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule Maximum Allowed Payments (SMAP)

| POLICY 1107.3 | Walkers (Rev.04/15,1/19) |
|---|---|

**Reimbursement Guidelines:**

A walker will be considered for coverage if all the following criteria (1-3) are met:

1) The member has a mobility limitation that significantly impairs the ability to participate in one or more mobility- related activities of daily living.

   A mobility limitation is one that:
   - Prevents the member from accomplishing a mobility related activity of daily living entirely; or,
   - Places the member at reasonable risk of morbidity or mortality secondary to the attempts to perform an activity of daily living; or
   - Prevents the member from completing activities of daily living within a reasonable time frame

2) The member is able to use the walker safely and effectively.

3) The functional mobility deficit can be sufficiently resolved by use of a cane or crutches.

**Coding Guidelines:**

Please refer to the schedule of maximum allowable fees (SMAP) for prior authorization requirements and billing or purchase options as these options vary for items in this policy. (Note: See section 1102.2a for Specialty Walkers.)

**A4636** - REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH

**A4637** - REPLACEMENT, TIP, CANE, CRUTCH, WALKER, EACH

**E0130** - WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT

**E0135** - WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT

**E0141** - WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT

**E0143** - WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT

**E0147** - WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE

**E0149** - WALKER, HEAVY DUTY, WHEELED, RIGID OR FOLDING, ANY TYPE

**E0153** - PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH

**E0154** - PLATFORM ATTACHMENT, WALKER, EACH

**E0155** - WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR

**E0156** - SEAT ATTACHMENT, WALKER

**E0157** - CRUTCH ATTACHMENT, WALKER, EACH

**E0158** - LEG EXTENSIONS FOR WALKER, PER SET OF FOUR (4)

**Limitations:**

- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule Maximum Allowed Payments (SMAP).

| POLICY 1108 | Infusion Therapy |
|---|---|

In-Home Infusion therapy allows members to deliver medication or nutrition through a needle or catheter directly into a vein. Many types of infusion services may be performed in the home and monitored by the member or caregiver. This type of service allows members to remain in the comfort of their home and significantly reduces the time spent in hospitals, clinics, or nursing facilities.

| POLICY 1108.1 | External Infusion Pump<br>(Added 10/15, Rev.04/16) |
|---|---|

An external infusion pump is a device that is typically carried or worn by a member that directly infuses drugs; most often subcutaneously and is administered either through prolonged infusion (>8 hours) or intermittent infusion (each episode lasting <8 hours). The drug is delivered at a regulated flow rate and under pressure through a programmed and controlled manner via a reservoir which eliminates the need for the patient to self-inject or to be confined to a hospital or other healthcare facility.

**Reimbursement Guidelines:**

External infusion pumps E0779 and E0781 are considered to be capped rental items. Once ten (10) rentals have been reimbursed, the device will be considered member owned. If the device is issued for short term use, then it will be returned to the provider after the duration of use and the provider retains ownership. External infusion pump E0780 is only available for purchase and is provided for members who require a reusable device that delivers intermittent infusions for less than eight (8) hours. Insulin infusion pumps E0779 and E0781 have a reasonable useful lifetime of five (5) years. E0780 is expected to last the duration of treatment of the drug for which it was ordered and may be replaced for additional episodes for which there has been at least a thirty (30 day) break in need.

Supplies for maintenance of a parenteral drug infusion catheter (A4221) are covered during periods of covered use at no more than four (4) units per month (1 per week). A4221 includes dressings for the catheter site and flush solutions not directly related to the drug infusion, all cannulas and needles, dressings, and infusion supplies. The catheter site may be a peripheral intravenous line, a peripherally inserted central catheter (PICC), a centrally inserted intravenous line with either an external or a subcutaneous port, or an epidural catheter.

Supplies used with the external infusion pump (A4222) are covered at a maximum of thirty-five (35) units per month. A4222 includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges, and preparation charges. These items may not be reported separately as this is considered unbundling of services.

Supplies used without an external infusion pump (A4223) for the in-home infusion of approved drugs (antibiotic therapy, or other approved Medicare Part D drugs, where applicable) are covered up to a maximum of one hundred and seventy-five units (175)

per month and are approved on a case-by-case basis through the PA process. Medical necessity and determination of appropriate units is based on the actual order which must align with the drug dosage and length of need. The duration requested (total months) on the prior authorization must be supported by the physician's order. (Added 04/16)

**Coverage Guidelines:**

An external infusion pump will be considered for coverage through the prior authorization process if the following criteria are met:

**Continuous Infusion (E0779):**

a) The treating physician has ordered an external infusion pump for the administration of a covered drug via continuous infusion to prevent hospital admissions or to allow the member to be discharged to the home setting; AND

b) A Certificate of Medical Necessity has been completed and signed by the physician, and submitted with the prior approval request

c) Parenteral administration of the drug in the home setting is medically necessary to administer the drug safely and effectively;

d) Other alternatives have been tried and failed where they exist;

e) A single drug is administered by a prolonged infusion of at least eight (8) hours;

f) The therapeutic regimen is proven or generally accepted to have clinical advantages over intermittent bolus administration regimens or infusions lasting less than eight (8) hours.

**Intermittent Infusion:**

a) The treating physician has ordered an external infusion pump for the administration of a covered drug via intermittent infusion (each episode lasting less than 8 hours and does not require the member to return to the physician's office prior to the beginning of each infusion) to prevent hospital admissions or to allow the member to be discharged to the home setting; AND

b) A Certificate of Medical Necessity has been completed and signed by the physician, and submitted with the prior approval request

c) Parenteral administration of the drug in the home setting is medically necessary to administer the drug safely and effectively;

d) Other alternatives have been tried and failed where they exist;

e) A single drug is administered by intermittent infusion lasting less than eight (8) hours;

f) Systemic toxicity or adverse effects of the drug are unavoidable without infusing it at a strictly controlled rate as indicated in the Physicians' Desk Reference, or the U.S. Pharmacopeia Drug Information.

**Multiple Channel Drug Infusion**

A multiple channel pump (E0781) allows for several different infusions at one time and features a programmable display to enter the prescribed rates, therefore, in addition to meeting the coverage criteria above for either continuous or intermittent infusion therapy, there must be a definitive reason why the least costly alternative E0779 or E0780 will not provide sufficient services, and a detailed description of the required multiple infusions.

**Coding Guidelines:**

Suppliers must request a prior authorization for external infusion pumps and supplies to be considered for coverage. An infusion pump may be rented for short-term or long-term use but must be returned to the provider after the period of medical necessity has ended for members who do not have length of need of at least ten (10) months. When Infusion is ordered on an intermittent basis (each episode lasting less than 8 hours) the purchase of E0780 will be required.

**External Infusion Pumps:**

**E0779 RR** - AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR GREATER

**E0780 NU** - AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR LESS

**E0781 RR** - AMBULATORY INFUSION PUMP, SINGLE OR MULITPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATION EQUIPMENT, WORN BY MEMBER.

**Supplies for External Infusion Pumps:**

**A4221 -** SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG SEPARATELY)

**A4222** - INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUGS SEPARATELY)

**Limitations:**

- Pumps will not be replaced prior to the end of the reasonable useful lifetime of the equipment (5 years).
- Pumps will be denied for use with drugs that are not covered by the Department or have not been approved for administration through infusion therapy in the home setting.
- Units in excess of what is allowed on the SMAP will be denied.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page1, Chapter 1100 are not met.

| POLICY 1108.2 | Insulin Infusion Pump (Rev. 01/10, 10/13, 04/15, 04/18) |
|---|---|

An external insulin infusion pump is a device that delivers insulin subcutaneously. The insulin is delivered in a programmed and controlled manner which eliminates the need for the patient to self-inject insulin. Insulin pumps are used to achieve near-normal blood glucose levels in order to prevent both acute and chronic complications of diabetes.

**Coverage Guidelines:**

An insulin infusion pump will be considered for coverage if the following criteria are met:

a) The member has a diagnosis of insulin dependent type 1 diabetes mellitus (diagnosed insulin dependent prior to age thirty (30) or gestational diabetes; AND

b) The treating endocrinologist or physician who is experienced in providing insulin infusion therapy orders an insulin pump and attests that he/she will monitor the members status while the device is used; AND

c) The physician documents a history of poor glycemic control on multiple daily injections of insulin, including a persistently elevated glycosylated hemoglobin level (HBA1C>7.0%); AND

d) The physician document additional history of poor control, such as:

1) Injection of insulin 3 or more times per day
2) More than 3 adjustments of daily dosage over the previous 6 months
3) Testing of sugar at least 4 times a day for the previous 2 months;
4) One documentation in the record of a fasting C-peptide level less than or equal to 110% of the lower limits of the normal range for the testing laboratory range or less than or equal to 200% of the lower limits of the normal range for individuals with a creatinine clearance of <50; AND
5) At least one of the following should also be present:

i. Glycosylated Hemoglobin level over 7%
ii. History of Hypoglycemia (less than 55) on more than 4 occasions in previous 4 weeks
iii. Wide fluctuations in blood glucose levels prior to mealtime
iv. Dawn phenomenon with fasting blood sugars over 200mg/DL on more than 3 times a week for 4 weeks

e) The member has demonstrated the ability and commitment to comply with the regimen of pump care, frequent self-monitoring of blood glucose, and careful attention to diet and exercise, and has received appropriate training on usage of the pump; AND

f) The insulin pump has a total coverage warranty for repair or replacement for four (4) years. After four (4) years Medicaid will allow a request for a replacement device if necessary.

**Coding Guidelines:**

Suppliers must request a prior authorization for an insulin infusion pump and associated supplies to be considered for coverage. The pump may be rented for short-term use but will be considered capped once ten (10) rentals have been reimbursed. A9276 is only covered for insulin infusion pumps that have a continuous glucose monitor incorporated into the device.

**A4230** - INFUSION SET FOR EXTERNAL INSULIN PUMP, NON-NEEDLE CANNULA TYPE

**A4231** - INFUSION SET FOR EXTERNAL INSULIN PUMP, NEEDLE TYPE

**A4232** - SYRINGE WITH NEEDLE FOR EXTERNAL INSULIN PUMP, STERILE, 3CC

**E0784** - EXTERNAL AMBULATORY INFUSION PUMP, INSULIN

**K0601** - REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 1.5 VOLT, EACH

**K0602** - REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 3 VOLT, EACH

**K0603** - REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, ALKALINE, 1.5 VOLT, EACH

**K0604** - REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 3.6 VOLT, EACH

**Limitations:**

- Pumps will not be replaced prior to the end of the reasonable useful lifetime of the equipment (4 years)
- Members who do not have a diagnosis of Insulin Dependent Type 1 or Gestational (insulin dependent) diabetes will not be covered
- Units in excess of what is allowed on the SMAP will be denied
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1108.3 | Parenteral Infusion Therapy (Rev. 04/15) |
|---|---|

Parenteral nutrition is used for members with medical conditions that impair the gastrointestinal absorption to a degree that is incompatible with life. This therapy will bypass the normal process of eating and digestion, and provide nutrients such as glucose, amino acids, lipids, vitamins, and other dietary minerals to members intravenously.

Parenteral infusion pumps and/or supplies are a covered service for in-home use if the member or caregiver is trained and capable of using the equipment without the

assistance of a clinical professional, and enteral nutrition is not feasible. If a skilled nursing visit has been approved through the Home Health Services Program, the home health agency must supply the pump and/or supplies. A skilled nursing visit may not be billed for this service.

No more than one month's supply of parenteral nutrition may be billed, and the items dispensed must not exceed the member's expected utilization. The member must see the ordering physician within thirty (30) days of writing an order for parenteral nutrition or recertifying the need for parental nutrition (revisions to an existing order do not require the physician to see the member but must be documented if the physician requires a face-to-face visit).

Providers are prohibited from billing more than one type of nutritional supply during the same month. Pumps will only be replaced after the reasonable useful lifetime of the equipment has expired.

**Coverage Guidelines:**

Parenteral Nutrition will be considered for coverage if the following criteria are met:

a) The member has a condition involving the small intestines and/or its exocrine glands which significantly impairs the absorption of nutrients; OR

b) The member has a disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and there is objective evidence supporting this diagnosis

**Coding Guidelines:**

Suppliers must request a prior authorization for a parental infusion pump and associated supplies to be considered for coverage. The pump may be rented for short-term use but will be considered capped once ten (10) rentals have been reimbursed. A4222 should be used to report supplies used with the parenteral nutritional infusion pump.

**Equipment and Supplies:**

**B9004 -** PARENTERAL NUTRITION INFUSION PUMP, PORTABLE

**A4222 -** INFUSION SUPPLIES FOR EXTERNAL INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUG SEPARATELY OR PARENTERAL SUPPLEMENT SEPARATELY)

**Formulas:**

**B4185**- PARENTERAL NUTRITION SOLUTION, PER 10 GRAMS LIPIDS

**B4189**- PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 10 TO 51 GRAMS OF PROTEIN - PREMIX

**B4193**- PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 52 TO 73 GRAMS OF PROTEIN – PREMIX

**B4197-** PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 74 TO 100 GRAMS OF PROTEIN – PREMIX

**B4199-** PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, OVER 100 GRAMS OF PROTEIN – PREMIX

**Limitations:**

- Parenteral nutrition is noncovered for members with a functional gastrointestinal tract
- Parenteral pumps are only eligible for replacement after the four (4) year reasonable useful lifetime of the device has expired
- Parental nutrition is reviewed and covered on a case-by-case basis through the prior authorization process, and will only be covered if approved
- These services will be considered noncovered if all policy specific guidelines are not met.
- These services will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1108.4 | iPort (Subcutaneous Injection Port) (Rev. 04/15) |
|---|---|

The injection port (I-port) functions as a medication delivery channel directly into the subcutaneous tissue. When applying the I-port, an insertion needle guides a soft cannula (a small, flexible tube) under the skin. Once applied, the insertion needle is removed and only the soft cannula remains below the skin, acting as the gateway into the subcutaneous tissue.

An I-port is a single use product cleared for up to 72-hour use and 75 individual injections. This results in approximately ten devices for each thirty days of use. An I-port is packaged in boxes of ten (a one-month supply). It is indicated for patients who administer multiple daily subcutaneous injections of physician prescribed medication, including insulin. The use of an iPort is designed to increase the member's comfort where multiple daily insulin injections are required.

**Coverage Guidelines:**

An iPort will be considered for coverage for an **initial three (3) month period** if all of the following criteria are met:

a) A Certificate of Medical Necessity has been completed and signed by the physician, and submitted with the prior approval request

b) The member has a medical condition that requires multiple (2 or more) subcutaneous, self-administered injections on a daily basis, and has current prescriptions for the injectable drugs for which it is ordered; AND

c) The order indicates the medication necessitating the need for iPort and is appropriate for this type of administration; AND

d) The member or the caregiver has been unsuccessful with the self-administration of injections using a standard needle and syringe due to a significant needle phobia or reaction, as evidenced by documented physical or psychological symptoms. Documented symptoms may include, but are not limited to, the following:

   Physical Symptoms

   - Changes in blood pressure,
   - Syncope,
   - Sweating,
   - Nausea
   - Pallor, and
   - Tinnitus

   Psychological Symptoms

   - Extreme anxiety
   - Insomnia
   - Panic attacks
   - Combativeness (resistance to needles/injections)
   - Elevated heart rate

**Recertification Guidelines:**

Recertification may be approved for up to twelve (12) consecutive months and will be required at least annually thereafter. Approval for the recertification of an iPort requires that all the criteria for the initial certification are met, and the member has demonstrated successful use of the device during the initial three (3) months and:

a) Recertification CMN is completed and submitted with the request for prior approval;

b) The member has experienced improved control of their medical condition through use of the device

**Coding Guidelines:**

Suppliers must request a prior authorization for coverage of an iPort.

**A4221** - SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER (I-Port), PER WEEK (LIST DRUG SEPARATELY)

**Limitations:**

- No more than 1 box (10 devices) will be covered per month
- No more than a 1-month supply will be reimbursed
- Noncovered as a convenience item for members who do not meet medical necessity criteria
- Noncovered for members using an external infusion pump
- Noncovered for members who do not have prior authorization
- Noncovered for members who are not living independently in the community home or who are locked into another program of service (home health, skilled nursing/nursing facility, or hospice)
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1109 | Nutritional Therapy or Supplementation Services |
|---|---|

Nutritional Therapy and Supplementation services are covered as a medical benefit for members under the age of twenty-one (21) through the DME program when there is a medical condition or inherited metabolic disorder.

These services are not covered when there is no medical condition supporting the need for the service, or as an additional resource due to exhaustion of another benefit such as WIC and food stamps, or for healthy babies with mothers electing to breast feed.

| POLICY 1109.1 | Enteral Nutrition<br>(Rev. 04/13, 04/15, 07/19,01/20) |
|---|---|

Enteral nutrition products are approved for members under the age of twenty-one (21) who require tube-delivered feedings and are unable to be sustained through an oral diet due to a major impairment of the gastrointestinal tract or associated structures which prevent food digestion or assimilation. All enteral nutrition therapy must be prior approved for coverage consideration.

The member or caregiver must be capable and willing to administer the enteral feedings as ordered by the physician. The provider of durable medical equipment is responsible for providing the appropriate educational training for the equipment and supplies they provide. Enteral feedings initiated for the convenience of the caregiver using either pureed foods or equivalent commercial food products are non-covered.

Documentation must be submitted to provide evidence that the member's family has exhausted all avenues of coverage available prior to requesting approval for these services through the DME program.

Example:

- WIC Funding (The number of ounces required per month exceeds the WIC ounces allowed. WIC allows 806 ounces per month for infants and 910 ounces per month for children (up to the age of five (5), and pregnant women with special dietary needs)

**Coverage Guidelines:**

Enteral nutrition products are covered as a medical benefit when the member meets **all** the following criteria:

1) The member is under the age of 21-years;
2) The member has an enteral access device;
3) The member has a specialized enteral formula ordered by the physician and is the primary source of nutrition;
4) The formula will be administered independently by the member or the caregiver, as ordered by physician;
5) The member has at least one of the following medical conditions:
    a. A disease or medical condition that impairs the members ability to ingest

sufficient calories and nutrients or restricts calories and nutrients in from reaching the gastrointestinal tract.

b. A disease or medical condition of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength properly proportioned to the members overall health status.
c. Inborn Error of Metabolism

All nutritional therapy service requests must be submitted with daily caloric intake needs noted on the Certificate of Medical Necessity (CMN) and prescription, as well as the route to be administered, diagnosis, length of need (not to exceed 12 months as recertification is required annually), signature of physician, and the date the physician signed the detailed written order or CMN.

Nutritional Enteral formulas are reimbursed on a per unit basis. Use the following formula to calculate units: Number of calories per day /100 X number of days billed = units. (e.g., A patient received 1450 calories per day, during the month of March 20xx. 1450 /100 X 31 days = 449.5 or 450 units (fraction of a unit should be rounded 1/2 or 5/10 (.5) is rounded up to the next whole unit). The detailed written order and certificate of medical necessity that is attached to the prior approval for nutritional formulas must include the number of calories per day the member will receive. The Department will determine the number of units to be used per month on the PA, not to exceed 900 units per month.

Coverage for enteral therapy will be approved initially for three (3) consecutive months. Further requests received following the initial three-month approval must indicate progress of member's growth and development, height and weight, and what steps are being taken to wean the member from formula or that removal of formula will never occur due to the specific diagnosis. Recertification may be approved for up to twelve (12) consecutive months and will be required annually thereafter. Formula that is not listed on the Schedule of Maximum Allowable Payments/Units should be sent to the Department on the Enteral Nutrition Therapy CMN form with medical necessity documentation attached. If approved, and the formula will be coded and priced based on the specific needs of the patient and description of the items provided, on a case-by-case basis.

**Coding Guidelines:**

Suppliers must request a prior authorization for enteral nutrition products, equipment, and supplies to be considered for coverage. Only a one-month supply may be submitted for reimbursement at a time.

No more than one HCPCS code with the total amount of approved units may be submitted for reimbursement at a time, with the exception of B4155, which may be used in addition to anther code for the replacement of nutritional elements in those patients who lack the ability to sustain optimal nutritional well-being without this supplementation.

Some examples include, but are not limited to the following disorders:

- pancreatic insufficiencies;
- amino acid deficiencies

***Claims submitted for Enteral Nutrition Supplies must be submitted with the purchase (NU) modifier.***

**B4034 -** ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

**B4035 -** ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

**B4036 -** ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

**B4081 -** NASOGASTRIC TUBING WITH STYLET

**B4082 -** NASOGASTRIC TUBING WITHOUT STYLET

**B4083 -** STOMACH TUBE - LEVINE TYPE

See below for additional supplies which may be requested through the prior approval process. These supplies are only approved through the DME program if the caregiver is changing the tube (a home health agency may not bill for these services).

**B4087 -** GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH

**B4088 -** GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH

**B9998 -** MIC-KEY EXTENSION

**Supplies are not age restricted, with exception of B9998-U1, which is up to thirty-six (36) months of age and B9998-U2, which is up to twenty-one (21) years of age.**

**B9998 U1 -** Mic-Key Gastrostomy Low-Profile Feeding Tube Kits include:

- Mic-Key Extension
- Low-profile feeding tube
- Connectors/clamps
- Bolus extension set
- Syringe and cap tip syringe
- Gauze

This kit will be covered at one (1) unit per month for member's ages 0-3 years (36 months). If the kit is billed, then no separate supplies may be reported during the same thirty (30) day period unless they are not included in the components listed as part of the kit. This kit is only approved for members who have been approved for enteral nutrition services and requires a prior authorization.

The prior authorization should include a three (3) component invoice (MSRP, Primary Discount, and Net Cost).

**B9998 U2** - GASTRIC PRESSURE RELIEF SYSTEM

This device will be covered at thirty (30) units per month for members under the age of twenty-one (21) years.

**ENTERAL FORMULAS:**

**B4149-** ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4150-** ENTERAL FORMULA, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4152-** ENTERAL FORMULA, NUTRITIONALLY COMPLETE, CALORICALLY DENSE (EQUAL TO OR GREATER THAN 1.5 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4153-** ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS AND PEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4154-** ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS, EXCLUDES INHERITED DISEASE OF METABOLISM, INCLUDES ALTERED COMPOSITION OF PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND/OR MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4155-** ENTERAL FORMULA, NUTRITIONALLY INCOMPLETE/MODULAR NUTRIENTS, INCLUDES SPECIFIC NUTRIENTS, CARBOHYDRATES (E.G. GLUCOSE POLYMERS), PROTEINS/AMINO ACIDS (E.G. GLUTAMINE, ARGININE), FAT (E.G. MEDIUM CHAIN TRIGLYCERIDES) OR COMBINATION, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4157-** ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4158-** ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4159-** ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4160-** ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4161-** ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**B4162-** ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT

**Note:** Procedure codes that are denied by NCCI procedure-to-procedure edits are considered non-covered by Medicaid as they are included in the payment for the base equipment or most comprehensive procedure or service when provided to the member on the same date of service. It is against the department's policy for any provider to resubmit claims for denied procedure codes on a different date of service in an attempt to avoid the NCCI/MUE edits. If this is discovered at any time by the department all items paid on another date of service will be recouped and the provider reported to the Office of Inspector General's Program Integrity Unit. (Part I Policies and Procedure for Medicaid/PeachCare for Kids Manual: Section 209.2; Georgia Medicaid applies the following billing requirements for submitting claims for reimbursement.)

**Limitations:**

- Noncovered for members over twenty-one (21) years of age
- Units in excess of 900 per month are noncovered
- Noncovered as a convenience item to the caregiver
- Noncovered in absence of a prescription and qualifying medical condition

- Noncovered for members who are underweight and have the ability to meet nutritional needs through the use of regular food consumption
- Noncovered due to exhaustion of another benefit without a medical need supporting policy guidelines
- Code combinations on the CMS NCCI procedure to procedure table as not payable when billed together (the lesser code denies) and codes that are billed in excess of the maximum units allowed on the MUE (medically unlikely edits) table
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1109.2 | Oral Medical Foods (Rev. 10/15) |
|---|---|

Oral nutrition will be considered for coverage when it is ordered by a physician and there is sufficient documentation to provide evidence that the member has an inborn metabolic or genetic error or disorder (i.e., PKU disease) or is unable to tolerate common food products, including liquid food in a can, in sufficient amounts to prevent mental retardation or death. Suppliers of nutritional products should submit a request for prior authorization for all orders received for nutritional products so that a determination can be made on a case-by-case basis where applicable.

**Coverage Guidelines:**

Medical foods require prior authorization and will be considered for coverage if the member meets **all** the following criteria are met:

1) The member has an inborn error of metabolism that interferes with the ability to metabolize specific nutrients, including, but not limited to:
    a) Phenylketonuria (PKU); or
    b) Homocystinuria; or
    c) Methylmalonic acidemia
2) The treating physician has ordered the most appropriate medical food based on the member's condition, that is:
    a) A medical food requiring a prescription; and
    b) A medical food that is labeled and used for the dietary management of a specific disease or disorder that presents specific nutritional requirements to avoid the development of physical or mental disabilities
3) The medical food is the primary source of nutrition (constitutes more than fifty (50) percent of the nutritional intake).

**Coding Guidelines:**

All requests for medical food products require prior authorization.

**S9435** - MEDICAL FOODS FOR INBORN ERRORS OF METABOLISM

**Reimbursement Guidelines:**

Medical foods are reimbursed based on manual pricing at 40% above the providers cost (shipping is not reimbursed) up to the Medicaid maximum allowable amount. Providers must submit their invoice during the prior authorization process for review and pricing. If MSRP is available, it must be included along with any primary discount applied to the purchase price. If this is not available, the provider will be reimbursed based on the actual cost (minus any shipping fees). Only one unit will be reimbursed for the total amount approved per month.

**Limitations:**

- Noncovered for members over twenty-one (21) years of age
- Amounts in excess of amount prior authorized per month are noncovered
- Noncovered as a convenience item to the caregiver
- Noncovered in absence of a prescription and qualifying medical condition
- Noncovered due to exhaustion of another benefit without a medical need supporting policy guidelines
- These supplies will be considered noncovered if all policy specific guidelines are not met.
  These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1109.3 | Electric Breast Pumps (Rev. 07/14, 01/15) |
|---|---|

Coverage for breast pumps through Georgia Medicaid is limited to instances where there is a medical condition, pre-term birth or low birth weight resulting in extended NICU stay or neurological or congenital anomalies affecting the ability of the baby to breastfeed naturally in the home.

Hospital grade electric breast pumps (E0604) are considered reasonable and necessary for infants who are separated from a breast-feeding mother due to a critical situation related to an underlying medical condition. During this period, the baby would remain hospitalized in the NICU unit, and the mother would be discharged. In this case, a rental period of up to three (3) months would be considered for coverage, and the pump must be returned to the provider.

NOTE: If the medical condition requiring the use of a breast pump is expected to continue after the baby is discharged to the home due to a neurological or congenital anomaly or oral deformity, then the physician should order the home use pump prior to or at the time of discharge. The hospital grade breast pump is rented during the inpatient stay and the home use pump is used after discharge. The DME provider should report the device using the baby's Medicaid ID number effective July 1, 2014.

**Coverage Guidelines E0604-RR:**

1) Prolonged infant hospitalization (NICU) after the mother is discharged due to pre-term birth, low birth weight or other congenital anomalies.

2) Infant is readmitted to the hospital during the first three (3) months of life.

**Coverage Guidelines E0603-NU:**

1) Baby has a congenital anomaly that interferes with the ability to breastfeed (Example: Cleft lip or palate, Down Syndrome, Pierre-Robin Syndrome, Oral deformity)
2) Baby has neurological issues (Example: Cerebral or Facial Palsy)
3) Long-term conditions causing sickness or weakness preventing the ability to breastfeed
4) NICU baby that is discharged to the home from a prolonged infant hospitalization requiring the use of a hospital grade rental pump

Home use electric breast pumps (E0603) are covered for babies with medical conditions that prevent natural breastfeeding abilities who have been discharged to the home. In this case, an electric breast pump would be purchased for use in the home for the duration of need, and the member retains ownership of the device.

**Coding Guidelines:**

Electric breast pumps do not require prior authorization unless the member is admitted to the hospital for greater than three months and the need for a hospital grade breast pump continues.

**E0603 NU**- BREAST PUMP, ELECTRIC (AC AND/OR DC), ANY TYPE

**E0604 RR**- BREAST PUMP, HOSPITAL GRADE, ELECTRIC (AC AND / OR DC), ANY TYPE

**Reimbursement Guidelines:**

**Effective 07/01/2014- Breast pumps must be reported using the baby's Medicaid ID to purchase a breast pump after discharge when medically necessary.**

No prior authorization is required for the rental or purchase of a covered breast pump as these items are subject to post payment review unless the infant is admitted for greater than 3 months and requires additional rentals. Providers must keep all supporting medical documentation on file for a minimum of five (5) years. All unsatisfied requests for documentation or documentation submitted that does not support the coverage criteria for the device provided will be subject to recoupment.

**Limitations:**

- E0604-RR maximum of three months rentals, per qualifying baby without a prior authorization
- E0603-NU maximum of one purchase, per qualifying baby (additional kits are not covered as the pump may be replaced if an additional pregnancy results in another baby that meets coverage criteria)

- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.

**Breast pumps for healthy babies are not a covered benefit through the DME program. Providers should refer requests for these devices to the WIC Program at http://www.wicprograms.org/state/georgia.**

**Georgia WIC Benefits**

Research has shown that there is no better food than breast milk for a baby's first year of life. Breastfeeding provides many health, nutritional, economical, and emotional benefits to mother and baby. Since a major goal of the WIC Program is to improve the nutritional status of infants, WIC mothers are encouraged to breastfeed their infants. WIC has historically promoted breastfeeding to all pregnant women as the optimal infant feeding choice, unless medically contraindicated.

WIC mothers choosing to breastfeed are provided information through counseling and breastfeeding educational materials. Breastfeeding mothers receive follow-up support through peer counselors. Breastfeeding mothers are eligible to participate in WIC longer than non-breastfeeding mothers. Mothers who exclusively breastfeed their infants receive an enhanced food package. Breastfeeding mothers can receive breast pumps, breast shells or nursing supplements to help support the initiation and continuation of breastfeeding.

| POLICY 1110 | Osteogenesis Stimulator (Rev. 04/13, 04/15) |
|---|---|

Electrical osteogenesis stimulators are devices that provide electrical stimulation to augment bone repair by stimulating the production of osteocytes (bone cells). Georgia Medicaid covers non-invasive devices that are ordered for use in the member's home. Noninvasive osteogenesis stimulators are characterized by an external power source that is attached to a coil or electrodes placed on the skin over a fracture or surgical bone fusion site.

Ultrasound stimulation is a noninvasive device that emits low intensity, pulsed ultrasound. The device is applied to the surface of the skin at the facture site and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing.

**Coverage Guidelines:**

For all osteogenesis stimulators the ordering physician must provide a documented plan of care indicating the nonunion status as confirmed by x-ray, the prescribed usage of the device must be listed, and the expected outcome must be listed. Osteogenesis Stimulators require prior authorization and are considered for coverage if all applicable policy criteria for the device ordered are met.

**A. Non-Invasive Stimulator (E0747)-**

An electrical osteogenesis stimulator (E0747) is covered only if the following criteria are met:

1) Nonunion of a long bone fracture defined by radiographic evidence, which includes two (2) sets of x-rays with multiple views, ninety (90) days apart, confirming fracture healing has ceased for three (3) or more months prior to starting treatment with the osteogenesis stimulator, **or**
2) Failed fusion of a joint other than in the spine where a minimum of nine (9) months has elapsed since the last surgery, **or**
3) Congenital pseudarthrosis.

**B. As it Relates to the Spine (E0748)-**

A spinal electrical osteogenesis stimulator is covered only if any of the following criteria are met:

1) Failed spinal fusion where a minimum of nine (9) months has elapsed since the last surgery, or
2) Following a multilevel spinal fusion surgery, or
3) Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

**C. Ultrasonic Osteogenesis Stimulator**

An ultrasonic osteogenesis stimulator (E0760) is covered only if **all** the following criteria are met:

1) Nonunion of a fracture documented by a minimum of two (2) sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of ninety (90) days. Each radiograph set must include multiple views of the fracture site accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; **and**
2) The fracture is not of the skull or vertebrae; **and**
3) The fracture is not tumor related.

**Coding Guidelines:**

Osteogenesis stimulators require prior authorization and will be covered as purchase only (NU) if approved.

**E0747**- OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS

**E0748**- OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS

**E0760**- OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE

For additional information on supporting diagnoses refer to CMS Policy at http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

**Limitations:**

- More than one type of device billed during the reasonable useful lifetime of the device, without an approved change in medical need will be denied
- These devices will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1111 | Pressure Reducing Support Surfaces (PRSS) (Rev. 04/15) |
|---|---|

Pressure reducing support surfaces are mattresses or overlays designed to prevent or promote the healing of pressure ulcers by reducing or eliminating tissue pressure. Pressure ulcers, also referred to as decubitus ulcers, and are lesions caused by unrelieved pressure between a bony prominence and an external surface that results in damage or necrosis of underlying tissue. These ulcers are staged based on location and severity. Most of these devices reduce interface pressure by conforming to the body's contour so that pressure is evenly distributed over a larger surface area.

**In accordance with CMS guidelines, the staging of pressure ulcers is as follows:**

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

- **Stage I –** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from surrounding area.

- **Stage II –** Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

- **Stage III –** Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

- **Stage IV** – Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

- **Unstageable** – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the member in the supine position with the head lying flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side lying position.

| POLICY 1111.1 | GROUP 1 Pressure Reducing Support Surfaces (PRSS) (Rev. 04/13, 04/15) |
|---|---|

Group 1 pressure reducing support surfaces are generally designed to either replace the mattress on a hospital bed or as an overlay which is an addition to the existing hospital bed mattress. These products include items such as foam, air or gel mattresses or overlays. The request for a hospital bed with a mattress and a Group 1 mattress will result in a denial as only one mattress will be reimbursed during the reasonable useful lifetime of the device.

**Coverage Guidelines:**

A Group 1 pressure reducing support surface is covered if the clinical documentation expresses the severity of the condition which sufficiently demonstrates the medical necessity for the pressure reducing support surface, there is a plan of care, and at least one of the following criteria are met:

1) The member is completely or partially immobile and cannot make changes in bodily position without assistance, or
2) The member has a pressure ulcer (any stage) and a least one of the following:
    a) Impaired nutritional status
    b) Altered sensory perception
    c) Incontinence (urinary or fecal)
    d) Compromised circulatory status

**Coding Guidelines:**

**Group 1**

A foam mattress (E0184) is characterized by all the following:

1) Foam height of 5” or greater, and
2) Foam with a density and other qualities that provide adequate pressure reduction, and
3) Durable, waterproof cover

**E0184** - DRY PRESSURE MATTRESS

An air (E0197) or gel (E0185) mattress is characterized by all of the following:

1) Foam height of 5” or greater of the air, water, or gel layer (respectively), and
2) Durable, waterproof cover

**E0185** - GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH

**E0197**- AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH

**Limitations:**

- Items submitted for approval that do not meet policy guidelines are noncovered.
- Devices that are used or bottom out are noncovered.
- Items that appear on the National Correct Coding Initiative (NCCI) procedure to
- procedure table will deny as included in another service (hospital bed with mattress billed with a PRSS mattress).
- This item will not be replaced more than once every three (3) years.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1111.2 | GROUP 2 Pressure Reducing Support Surfaces (PRSS) (Rev. 04/15) |
|---|---|

Group 2 pressure reducing support surfaces are generally designed to replace either the mattress on a hospital bed or as an overlay which is an addition to the existing hospital bed mattress. These products include items such as powered or non-powered advanced pressure reducing air mattresses and overlays.

**Coverage Guidelines:**

A Group 2 pressure reducing support surface is covered if the clinical documentation expresses the severity of the condition which sufficiently demonstrates the medical necessity for the pressure reducing support surface, there is a plan of care, and at least one of the following three criteria applies:

1) The member has multiple stage II pressure ulcers located on the trunk or pelvis (Report ICD- 9 707.02-707.05 on or before 09/30/2015, and ICD-10 L89.11-L89.45 on or after 10/01/2015) which have failed to improve over the past month, during which time the member has been on a comprehensive ulcer treatment program including each of the following:
    a) Use of an appropriate group 1 support surface, and
    b) Regular assessment by a nurse or physician, or other licensed healthcare practitioner, and
    c) Appropriate turning and positioning, and
    d) Appropriate wound care, and
    e) Appropriate management of moisture/incontinence, and
    f) Nutritional assessment and intervention consistent with the overall plan of care
2) The beneficiary has large or multiple state III or IV pressure ulcer(s) on the trunk or pelvis,
3) The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last sixty (60) days, and has been on a group 2 support surface immediately prior to discharge from a hospital or nursing facility within the past thirty (30) days

If a request is submitted for a group 2 pressure reducing support surface for a member following a myocutaneous flap or skin graft, coverage will be limited to two (2) rentals (60 days). For all other members who meet policy guidelines, coverage will be limited to the lesser of the months for which it is ordered or ten (10) rentals. After ten (10) rentals have been reimbursed, the device is considered to be owned by the member.

**Coding Guidelines:**

Suppliers must request a prior authorization for Group 2 pressure reducing support to be considered for coverage. Group 2 support surfaces are covered as a rental only.

**Group 2**

A powered pressure reducing support surface (E0277- alternating pressure, low air loss, or powered flotation without low air loss) is characterized by all of the following:

1) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and
2) Inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and
3) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate member lift, reduce pressure, and prevent bottoming out, and
4) A surface designed to reduce friction and shear, and
5) Can be placed directly on a hospital bed frame

**E0277**- POWERED PRESSURE-REDUCING AIR MATTRESS

An advanced nonpowered pressure-reducing mattress overlay (E0371) is characterized by all of the following:

1) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out, and
2) Total height of 3 inches or greater, and
3) A surface designed to reduce friction and shear, and
4) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces

**E0371**- NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH

A powered pressure reducing mattress overlay (E0372- low air loss, powered flotation without low air loss, or alternating pressure) is characterized by all of the following:

1) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and
2) Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and

3) Height of the air chambers, proximity of the air chambers to on another, frequency of air member lift, reduce pressure and prevent bottoming out, and
4) A surface designed to reduce friction and shear

**E0372**- POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH

An advanced nonpowered pressure reducing mattress (E0373) is characterized by all of the following:

1) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out, and
2) Total height of 5 inches or greater, and
3) A surface designed to reduce friction and shear, and
4) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces, and
5) Can be placed directly on a hospital bed frame

**E0373**- NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS

**Limitations:**

- Items submitted for approval that do not meet policy guidelines are noncovered.
- Devices that are used or bottom out are noncovered
- Items that appear on the National Correct Coding Initiative (NCCI) procedure to procedure table will deny as included in another service (hospital bed with mattress billed with a PRSS mattress).
- This item is limited to ten (10) rental months and will then be considered member owned.
- This item will not be replaced more than once every three (3) years.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112 | Respiratory Services (Rev. 04/15, 07/16) |
|---|---|

Respiratory Services are covered by Georgia Medicaid for members with disabilities and chronic medical conditions (i.e., Chronic Obstructive Pulmonary Disease (COPD), Central Sleep Apnea, Obstructive Sleep Apnea, Cystic Fibrosis, Pulmonary Fibrosis, Bronchiectasis, Pediatric Bronchopulmonary Dysplasia (BPD), Chronic Severe Angina with Hypoxemia, etc.) involving the respiratory system that require specialized medical equipment to for the member to be able to functionally participate in the normal activities of daily living in their home environment. This type of equipment includes items such as infant apnea monitors, oxygen concentrators, ventilators, and nebulizers.

**Supplier Requirements for Complex Respiratory Services**

**Complex Respiratory Suppliers** are determined by the scope of service and includes suppliers that meet the following criteria:

1) Effective September 30, 2009. Complex Respiratory Suppliers must be accredited by one of the following accepted Accreditation Organizations:

   - The Joint Commission (TJC)
   - Commission on Accreditation of Rehabilitation Facilities (CARF)
   - Community Health Accreditation Program (CHAP)
   - Healthcare Quality Association on Accreditation (HQAA)
   - Accreditation Commission for Healthcare (ACHC)
   - American Board for Certification in Orthotics & Prosthetics, Inc. (ABC)
   - Board of Certification/Accreditation, International (BOC)
   - The Compliance Team

2) A complex respiratory supplier must employ or be a Licensed Registered Respiratory Technologist (RRT) or a Licensed Certified Respiratory Technologist (CRT). The licensure must be valid at all times during which the provider is enrolled with Georgia Medicaid.
3) The RRT or CRT must be employed by one supplier only and may not provide services to additional providers.
4) A complex respiratory supplier must provide service coverage seven (7) days a week if necessary and provide delivery service free of charge for items provided to Medicaid members.
5) A complex respiratory supplier must have a warehouse and qualified repair staff available during normal business hours.
6) A complex respiratory supplier is required to have a credentialed respiratory therapist deliver, set-up and teach/instruct on safety and usage of the equipment to ensure that the member or caregiver is able to use the equipment properly.
7) A complex respiratory supplier may provide all respiratory services with no restriction to the codes including oxygen for children.

**Non-complex Respiratory Suppliers** are determined by the scope of service and includes suppliers that meet the following criteria:

1) Effective September 30, 2009. Complex Respiratory Suppliers must be accredited by one of the following accepted Accreditation Organizations:

   - The Joint Commission (TJC)
   - Commission on Accreditation of Rehabilitation Facilities (CARF)
   - Community Health Accreditation Program (CHAP)
   - Healthcare Quality Association on Accreditation (HQAA)
   - Accreditation Commission for Healthcare (ACHC)
   - American Board for Certification in Orthotics & Prosthetics, Inc. (ABC)
   - Board of Certification/Accreditation, International (BOC)
   - The Compliance Team

2) A non-complex respiratory supplier must provide service coverage seven (7) days a week if necessary and provide delivery service free of charge for items provided to Medicaid members.
3) A non-complex respiratory supplier must have a warehouse and qualified repair staff available during normal business hours.
4) A non-complex respiratory supplier must be responsible for all delivery, set-up and teaching/instructing to ensure that the member or caregiver is able to use the equipment properly.
5) Non-complex respiratory suppliers may only provide:
   a) Oxygen to adults (members twenty-one (21) years of age and older)
   b) Nebulizers (E0570) **Please Note:** Nebulizers do not require prior authorization; however, the provider must have all required documentation on file. E0570 must be reported with the (NU) modifier for equipment purchase or without a modifier for rental (do not report E0570 with the rental modifier RR).

| POLICY 1112.1 | **Apnea Monitors (Infant)** (Rev. 04/13, 07/13, 11/13, 10/14, 04/15) |
|---|---|

Infant apnea monitors are devices that are designed to detect the cessation of breathing either directly through measurement of respiration and /or indirectly through monitoring of physiological signs such as heart rate, pulse, or blood oxygen concentration. These devices typically feature both video and audio alarm systems. Some devices may differentiate between the detection of obstructive apnea (often caused by mucous or oropharyngeal membrane) and central apnea (often caused by organ system failure). The device must be capable of recording in real-time and have downloading capabilities to be considered for coverage.

**Coverage Guidelines:**

Infant apnea monitors are covered for infants whose medical record documents episode(s) of apnea and/or bradycardia that are considered to be apparent life-threatening events with at least one of the following indications:

a) Gastrointestinal reflux resulting in apnea, bradycardia, or oxygen desaturation
b) Apnea accompanied by marked hypotonia
c) Respiratory Syncytial Virus (RSV)

d) Whooping cough (includes Pertussis)
e) Infants with tracheostomies or anatomic abnormalities that compromise the airway
f) Infants with chronic lung disease (i.e., Bronchopulmonary dysplasia), especially those requiring the use of oxygen, CPAP, or mechanical ventilation
g) Infants at high risk of recurrent episodes of prolonged apnea with duration greater than 20 seconds, bradycardia (heart rate of less than 80 beats per minute) and hypoxemia (oxygen saturation below 90 percent) after hospital discharge, until the infant is event-free for six (6) weeks
h) Sibling of an infant that died as a result of Sudden Infant Death Syndrome (SIDS)

Georgia Medicaid will reimburse the initial request for the infant apnea monitor for a maximum duration of four (4) rental months for an infant up to one (1) year of age. Children with tracheotomies will be eligible for an extended coverage period for rentals of the apnea monitor for up to twenty (20) additional months (two (2) years total) if it is still considered medically necessary by the treating physician at three (3) month intervals at which time the prior authorization must be renewed.

Prior authorization requests for an extended rental period must include the following attachments:

1) A certificate of medical necessity (CMN) indicating the extended time period requested (no more than three (3) months permitted) with specific medical documentation that supports the continuation of medical necessity.
2) A one (1) page download summary from the physician indicating the continued apnea or bradycardia events. The summary must be signed and dated by the physician.

Requests for extension of coverage will be approved at a maximum of three (3) month intervals. Additional information may be requested by the Department (sleep study for members over one (1) year age, etc.) in order to determine the device is still medically necessary.

The Department will only reimburse monitors that record and document in real time. The provider must download the apnea monitor results and send the report to the ordering physician who prescribed use of the monitor for review and signature before the device can be recertified for an extended rental period. The provider must check for member compliance through necessary home visits and the use of telephone modem. **The manufacturer's name and model number must be indicated on the request, or the PA may be denied.**

The provider is responsible for the delivery, initial set-up and teaching/instructing on the use of the device to ensure that the member or caregiver is able to use the equipment safely and effectively. Home health agencies may not bill for training, downloading of results, or home visits to check for compliance with the device through the DME program.

The Department does not reimburse for use of in-home apnea monitors through the DME program until the member has been discharged from the hospital and is residing in their own community home (typically, place of service 12).

**Coding Guidelines:**

Suppliers must request a prior authorization for infant apnea monitors to be considered for coverage. Apnea monitors are only reimbursed as a monthly rental (RR).

**E0619-** APNEA MONITOR, WITH RECORDING FEATURE

**Limitations:**

- Apnea monitors are noncovered for members who have not been discharged to their community home (typically, Place of Service 12 is reported)
- Initial requests for infant apnea monitors are limited to a maximum of four (4) months
- Coverage limited to four (4) months for members who are not trach dependent
- Extended requests are limited to a combined total of twenty-four (24) rental months four (4) initial months and then up to an additional twenty (20) months)
- Claims for apnea monitors without a valid prior authorization will be denied
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112.2 | **Automatic External Defibrillator (AED)** (Implemented 10/12, Rev. 04/15) |
|---|---|

A wearable automatic external defibrillator is a device that is compact and portable and worn in a vest. The device is used to deliver an electrical shock to members who experience sudden cardiac arrest. These devices use a microprocessor to interpret a member's heart rhythm through electrodes which recognizes ventricular fibrillation or ventricular tachycardia, and then automatically delivers an electrical shock.

**Coverage Guidelines:**

Automatic external defibrillators are covered for members who are in the waiting period for either an initial implantation or revision or explanation of an existing implantable cardioverter defibrillator. Georgia Medicaid limits the coverage of this device to a maximum of six (6) months per operative procedure (*excludes members under twenty-one (21) years of age that require the device while waiting on a heart transplant. These members may receive a coverage determination through the prior approval process every three (3) months*). The surgery should be scheduled within ninety (90) days of the order of the device which will limit the rental period to three (3) months on the initial prior approval. If the surgery is rescheduled by the surgeon or a physician due to medical concerns, then up to an additional three (3) months will be considered for coverage. Documentation must be submitted with the initial request for approval that contains the physician's order, the date of the scheduled surgical procedure, and any additional

supporting documentation. Providers will be required to attest to a face-to-face evaluation that must have occurred within six (6) months prior to the order for the device and should have this documentation on file and available upon request.

Providers must submit a new prior authorization and new order for requests of coverage beyond the initial three (3) months period. A new order and finalized date for the rescheduled procedure must be included. If the face-to-face evaluation for the initial order has expired (six months has elapsed) then a new face-to-face must have occurred before the device will be recertified.

An automatic external defibrillator will be considered for coverage if the member meets on of the following criteria (1-2):

1) The member is in the waiting period for a scheduled implantation or revision of an implantable cardioverter defibrillator
2) The member is in the waiting period for a scheduled explanation of a previously implanted defibrillator
3) The member has been approved (Phase 1) and is on the waiting list for a heart transplant, or the member is currently in Phase 2 (waiting period) of the heart transplant process.

**AND** one of the following criteria are met (a-c):

a) There is a documented episode of ventricular fibrillation or a sustained, lasting longer than thirty (30) seconds, ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an electrophysiological (EP) study, but may not be due to a transient or reversible cause and not occur during the first forty-eight (48) hours of an acute myocardial infarction; **OR**

b) Member has familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy; **OR**

c) There is a documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction less than or equal to 0.35;

**Coding Guidelines:**

Suppliers must request a prior authorization for automatic external defibrillators to be considered for coverage. Automatic external defibrillators are only reimbursed as a monthly rental (RR).

**K0606 -** AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS, GARMENT TYPE

Replacement components and supplies (K0606-K0609) used in conjunction with an automatic external defibrillator are not separately reimbursed as they are considered to be included in the rental reimbursement. Requests for approval of these items or claims submissions will be denied as this considered unbundling.

**Limitations:**

- Limited to six (6) rentals (6 months) per implantation, revision, or explanation of an implantable cardioverter defibrillator
- Initial approval is limited to a maximum three (3) months
- Noncovered for use of members who are not living in their own home (noncovered members who live in a facility or considered to be an inpatient)
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112.3 | **Continuous Positive Pressure Airway Devices and Accessories (CPAP/ BIPAP)** **(Rev. 04/13, 04/15, 07/15)** |
|---|---|

A continuous positive airway pressure (CPAP) device is a noninvasive method of providing air pressure through the member's nostrils, usually through a nasal mask or flow generator system. A CPAP delivers single pressure continuously and assists the member in nocturnal respiration, particularly when the member's oropharyngeal tissues relax, collapse, and/or obstruct the normal airflow, causing a variety of symptoms. These devices are used primarily in conservative therapy (vs. surgery) for members with obstructive sleep apnea (OSA). In such instances, the CPAP acts as a pneumatic splint of the upper airway and is considered the treatment of choice for OSA. In order to assure adequate treatment results, an optimal CPAP pressure is determined by conducting a titration study, where the pressure is gradually increased until the sleep-related breathing episodes are eliminated in all stages and positions of sleep.

For children, adenotonsillectomy is often the first line of treatment with OSA, assuming that appreciable adenotonsillar tissue is present. This type of procedure may improve upper airway patency enough to improve or resolve the OSA. Positive airway pressure therapy through a nasal mask (continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BIPAP) can be used to provide a splint when OSA is diagnoses with minimal adenotonsillar tissue, when OSA persists despite an adenotonsillectomy, or when this procedure is contraindicated.

**Coverage Guidelines Pediatric (less than 21 years of age):**

For members who are under twenty-one (21) years of age, the following criteria must be met, and documentation must be submitted during the request for prior approval for coverage of a CPAP (E0601) or BIPAP (E0470) to be considered:

Obstructive sleep apnea (OSA) in children (<21 years of age) must be diagnosed by:

1) Nocturnal polysomnography (within the six (6) months prior to the order) with an AHI > five (5) episodes per hour with a history and exam consistent with OSA,

   **OR**

2) Nocturnal pulse oximetry (within the six (6) months prior to the order) with three (3) or more SpO2 drops <90% and three (3) or more clusters of desaturation events, or alternatives desaturation (>3%) index >3.5 episodes per hour, OR
3) Consultation with a sleep medicine specialist

Polysomnography and/or consultation with a sleep medicine specialist to support the diagnosis of OSA and/or to identify perioperative risks are recommended for:

1) High risk children (i.e., children with craniofacial abnormalities, neuromuscular disorders, Down's syndrome, etc.)
2) Children with equivocal indications for adenotonsillectomy (such as discordance between tonsillar size on physical examination and the reported severity of sleep-disordered breathing)
3) Children younger than three years of age

   **Note:** Members with respiratory insufficiency due to cystic fibrosis may be used as a bridge to lung transplantation

Adenotonsillectomy is an appropriate first line treatment for children with OSA. Weight loss is recommended in addition to other therapy for members who are overweight or obese. Adenoidectomy without tonsillectomy is only covered when a child with OSA has previously had a tonsillectomy, when tonsillectomy is contraindicated, or when tonsillar hypertrophy is present. Intranasal corticosteroids are an option for children with mild OSA in whom adenotonsillectomy is contraindicated or for mild postoperative OSA.

**Initial coverage** A CPAP is considered for coverage for an initial three (3) month trial for period for children under the age of twenty-one (21) who have:

1) Undergone surgery or are not candidates for surgery, AND
2) Have documented residual sleep apnea symptoms (sleep disruption and/or significant desaturations) with residual daytime symptoms (excessive daytime sleepiness or behavioral problems)

**Continued coverage** A CPAP is considered for continued coverage for children under that age of twenty-one (21) if criteria one (1) is met and one of criteria two (2) or three (3) are also met:

1) There is documented improvement in sleep disruption, daytime sleepiness, and behavioral problems with use of the CPAP, **AND**
2) The member has been reevaluated for continued use of the CPAP and demonstrates ongoing clinical benefit and compliance with use, defined as use of CPAP for at least four (4) hours per night on 70% of the nights in a consecutive thirty (30) day period (remainder of the rental period considered for approval);

   **OR**
3) The member has been reevaluated for continued use of the CPAP within the first ninety (90) days and demonstrates ongoing clinical benefit from use of the device during periods of use, but due to pediatric age (less than twenty-one (21) years of age) or conditions that affect behavior (autism, etc.) and the ability to meet

standard compliance guidelines will be considered on a case-by-case basis through the prior approval process. Members that meet these criteria for extended coverage will be considered for reimbursement of the remaining seven (7) rental months. In order to receive the remaining seven (7) rentals in the ten (10) month rental period, the member must be compliant for at least two – four (2-4) hours per night on 40% of the nights in a consecutive thirty-day period. (Rev. 07/15)

**Coverage Guidelines Adult (21 years of age or older):**

For members who are twenty-one (21) years of age or older, the following criteria must be met, and documentation must be submitted during the request for prior approval for coverage of a CPAP (E0601) or BIPAP (E0470) to be considered:

a) The member has had a face-to-face clinical evaluation by the treating physician prior to a sleep test to assess the member for obstructive sleep apnea; and

b) A polysomnography was performed in a facility-based sleep center or laboratory (Type 1) or in the home or mobile facility (Type 2) within the six (6) months preceding the order that demonstrates a positive diagnosis of OSA; and

c) The member's Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) must be consistent with <u>one (1) of the following</u>:

- greater than or equal to (≥) fifteen (15) events per hour, based on a minimum of two (2) hours of sleep; or
- between five (5) and fourteen (14) events with additional symptoms including <u>one or more</u> of the following (a-d):

    i. Excessive daytime sleepiness as documented by a score of greater than ten (10) on the Epworth Sleepiness Scale or daytime sleepiness interfering with activities of daily living that is not attributable to another modifiable sedating condition (e.g., narcotic dependence); or
    ii. Documented hypertension; or
    iii. Ischemic heart disease; or
    iv. History of Stroke

d) The member or caregiver has received instruction from the supplier of the PAP device and accessories on the proper use of the equipment and has agreed to be compliant with use of the device.

**Note:** Members with respiratory insufficiency due to cystic fibrosis may be used as a bridge to lung transplantation.

**BIPAP Coverage Guidelines (E0470 or E0471):**

If the member meets all coverage criteria for a CPAP (E0601) device (a-c), and a CPAP device has been tried and proven ineffective, then a BIPAP (E0470) will be considered for coverage.

Coverage Guidelines for a Respiratory Assistive Device (E0471) will be considered if the member meets the following criteria:

a) The member's physician has ordered a BIPAP ST for in-home use for a member at risk of requiring mechanical ventilation; and

b) The treating physician has documented symptoms of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

c) Member is in a clinical disorder group characterized as one of the following:

    i. Restrictive thoracic disorder (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities)
    ii. Severe chronic obstructive pulmonary disease (COPD)
    iii. Central sleep apnea (CSA)

In addition to meeting one requirement contained in criteria A-C, the member must also meet the following criteria based on the specific disorder group:

I. Restrictive Thoracic Disorders:

1) An arterial blood gas PaCO2, done while awake and breathing the patient's usual FIO2 is greater than or equal to 45 mm Hg, or

2) Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the patient's usual FIO2, or

3) For a progressive neuromuscular disease (only), maximal inspiratory pressure is less than 60 cm H20 or forced vital capacity is less than 50% predicted, and

4) Chronic obstructive pulmonary disease does not contribute significantly to the member's pulmonary limitation

II. Severe COPD:

1) An arterial blood gas PaCO2, done while awake and breathing the patient's usual FIO2, is greater than or equal to 52 mm Hg, and

2) Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO2 (whichever is higher), and

3) Prior to initiating therapy, Obstructive Sleep Apnea (OSA) and treatment with a continuous positive airway pressure device (CPAP) has been considered and ruled out

III. Central Sleep Apnea or Complex Sleep Apnea:

Prior to initiating therapy (within the previous six (6) months), a complete facility-based, attended polysomnogram must be performed documenting the following:

1) The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA), and

2) The ruling out of CPAP as effective therapy if either CSA or OSA is a component of the initially observed sleep-associated hypoventilation, and;

3) Significant improvement of the sleep-associated hypoventilation with the use of an E0471 device on the settings that will be prescribed for initial use at home, while breathing the patient's usual FIO2.

Central sleep apnea (CSA) is defined as:

- An apnea-hypopnea index (AHI) greater than 5 and;
- Central apneas/hypopneas greater than 50% of the total apneas/hypopneas and;
- Central apneas or hypopneas greater than or equal to 5 times per hour and;
- Symptoms of either excessive sleepiness or disrupted sleep

**Note:** The polysomnography (sleep study) must have been performed within six (6) months prior to the submission of a prior authorization. Sleep studies may be performed in the home, a mobile facility, a hospital, sleep laboratory or by an Independent Diagnostic Treatment Facility (IDTF). For members under the age of 21-years, the sleep study must be performed in a facility-based sleep study laboratory (Type 1 sleep study). An in home or mobile facility sleep study (Type 2 sleep study) may be performed for members over the age of 21-years. For a study to be reported as a polysomnogram, sleep must be recorded and staged. A sleep specialist (i.e., pulmonologist, otolaryngologist, neurologist, etc.) or the physician treating the condition that requires the respiratory assistive device can prescribe the device and interpret the sleep study. The physician must indicate his/her specialty on the certificate of medical necessity (CMN).

**Initial coverage** of CPAP/BIPAP is limited to a three (3) month rental period to identify individuals who benefit from CPAP therapy, and to establish continued compliance and need.

**Continued Coverage** of CPAP/BIPAP therapy is considered for members with a qualifying diagnosis who meets policy guidelines and who, during the initial three (3) month rental period met ALL the following criteria:

a) were compliant with the prescribed treatment; and

b) demonstrated clinical improvement as a result of CPAP therapy

c) has documentation from the treating physician that the member is compliant and that the medical need still exists.

For this policy, compliance is defined as documented consistent use of CPAP for either:

1) greater than or equal to (≥) four (4) hours for five (5) days each week for at least 70% of the time for a thirty (30) consecutive day period any time during the first three (3) months of coverage in the trial period;

2) average of four (4) hours per day of CPAP availability

**Coding Guidelines:**

All PAP devices require prior authorization to be considered for coverage. These devices are rented for no less than three (3) rental months before a determination for compliance and continued coverage can be established. The device is considered to be owned by the member after ten (10) rentals have been reimbursed. Replacements of base equipment and accessories will not be approved prior to the reasonable useful lifetime of the device or accessory.

**Equipment and Accessories:**

**E0601** - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE

**E0470** - RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

**E0471** - RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

**E0561 -** HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE

**E0562** - HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

**Supplies** (refer to SMAP for coverage maximum units and billing period)

All supplies and replacement components require prior approval. Requests for recurring supplies must be submitted with an order documenting the necessary supplies and the length of need (not to exceed 12 months) that is signed and dated by the physician. The provider must contact the member or caregiver before supplies are refilled to ensure the member is still using the device and the current supplies are near exhaustion. Suppliers must not deliver refills without a request from the member or caregiver. A signed and dated delivery ticket by the member or caregiver or tracking number for shipped supplies with a packing slip will support this requirement and must be kept on file.

**A4604** - TUBING WITH INTEGRATED HEATING ELEMENT FOR USE WITH POSITIVE AIRWAY PRESSURE DEVICE

**A7027** - COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH

**A7028** - ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH

**A7029** - NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR

**A7030** - FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH

**A7031 -** FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH

**A7032 -** CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH

**A7033** - PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR

**A7034** - NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP

**A7035** - HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE

**A7036** - CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE

**A7037** - TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE

**A7038** - FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

**A7039** - FILTER, NON-DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

**A7044** - ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH

**A7046** - FILTER, NON-DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

**Reimbursement Guidelines:**

Equipment provided must be new and have a manufacturer's warranty. The provider is responsible for set-up and training on the proper use of the equipment and related supplies. A CPAP/BIPAP for sleep apnea will be prior approved for a maximum of ten (10) rental months and will then be considered to be capped and member owned. Providers must check compliance of the device by ensuring the member still requires supplies during the ten (10) months and maintain the documentation in their records for audit purposes. If a member is documented as noncompliant, that member may be warned. If compliance issues continue, the provider must retrieve the device and humidifier (if provided) and not bill Medicaid for any approved months of use remaining on the approval.

The provider is responsible for the set-up and training of the equipment. Set-up, training /education, home visits and associated professional services must be performed by a credentialed respiratory therapist (RT) or a certified sleep technologist.

All supplies and replacement parts are covered through the prior approval process using the appropriate HCPCS procedure code (s). A request for recurring supplies must be submitted and signed for by a physician.

**Limitations**

- Sleep studies that are not dated within the six (6) months prior to the order for therapy will be excluded from coverage.

- Members over the age of twenty-one (21) who are noncompliant during the first three (3) months of use will not be covered for additional rental months.
- Members under the age of 21 who are either noncompliant or not approved for an extended rental period on a case-by-case basis will not be covered for additional rental months.
- Supplies will not be separately reimbursed upon delivery of the device.
- E0470- will not be covered unless the member has tried and failed the initial therapy period with a CPAP device (E0601).
- E0471- will not be covered for members with a diagnosis of OSA (obstructive sleep apnea)
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112.4 | Nebulizers and Accessories (Rev. 04/13, 04/15) |
|---|---|

Nebulizers are devices used to deliver aerosol medications for the treatment of many respiratory related conditions and diseases. A nebulizer with compressor is an aerosol compressor delivering a fixed low pressure, typically used with a small volume nebulizer that delivers vaporized medication and/or solution through inspiration directly into the lungs and bronchi. This type of equipment is ordered when an inhaler is does not meet the needs of the member.

**Coverage Guidelines:**

A small-volume nebulizer with compressor (E0570) does not require a prior authorization. A member must meet ALL the following criteria to submit for reimbursement of a nebulizer:

a) The provide must have a written order from the treating physician on file for a nebulizer with compressor and related supplies that includes the supporting diagnosis, and specific drug for which the nebulizer will be used, and be signed and dated by the physician (face-to-face must have occurred within the six (6) months prior to the written order); and

b) The written order must document that the member has one of the following diagnoses:

    - Abnormal Sputum
    - Asthma
    - Bronchiectasis
    - Chronic bronchitis
    - Chronic obstructive pulmonary disease (COPD)
    - Congenital Bronchiectasis
    - Complications of a transplanted organ
    - Cystic Fibrosis with pulmonary manifestations
    - Emphysema
    - Human Immunodeficiency Virus (HIV) Disease

- Pneumonia due to Adenovirus
- Pneumocytosis
- Respiratory conditions due to unspecified agent
- Tuberculosis

c) The provider must have a delivery ticket on file with a detailed description of what was provided and the signature and date of the member or caregiver. (Claims may not be submitted prior to delivery)

**Reimbursement Guidelines:**

A supplier may bill a nebulizer with compressor (E0570) and the related accessories (A7005 and A7015) on the initial claim for the purchase of the device as these items are not included in the reimbursement of the base code.

Repairs:

The Department will not reimburse for repairs of a nebulizer, and the device will not be replaced until it has reached the reasonable useful lifetime (refer to SMAP for code specific billing periods).

Replacement Supplies:

The medication holder and tubing may be reimbursed by using the appropriate accessory codes (A7015 NU and/or A7005 NU). Prior approval is not required. Nebulizers are subject to post payment review and are subject to recoupment if all policy guidelines have not been met or if utilization exceeds the listed maximum units for a specified billing period (See SMAP).

**Coding Guidelines:**

No prior authorization is required for a nebulizer and supplies. Limitations are contained on the schedule of maximum allowable payments (SMAP). Suppliers must ensure all policy guidelines are met and all documentation is on file as this may be requested during a post-pay review or audit.

**E0570 -** NEBULIZER, WITH COMPRESSOR

**A7005 -** ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, NON-DISPOSABLE

**A7015 -** AEROSOL MASK, USED WITH DME NEBULIZER

**Limitations:**

- Nebulizers that issued without appropriate documentation on file will be subject to post-pay recoupment
- Nebulizers that are issued to members who do not meet policy guidelines will be subject to post-pay recoupment
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.

- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Devices and supplies billed in excess of the maximum allowed for the defined billing period on the schedule of maximum allowable payments will be subject to post-pay recoupment

| POLICY 1112.5 | Altera Nebulizer and Accessories (Replacement Only) (Implemented 07/14) |
|---|---|

Altera Nebulizer Systems are dispensed with the initial order for aztreonam inhalation solution (Cayston) and are not separately reimbursed. Altera Nebulizers come with a standard two (2) year limited manufacturer's warranty that covers the Altera Nebulizer System, Controller, Nebulizer Connection Cord, and Power Supply. These devices are considered for coverage by Georgia Medicaid as a replacement only, after the two (2) year warranty has expired (two years from the date the device is dispensed). Providers requesting a replacement nebulizer must provide documentation indicating when the initial order for Cayston and the Altera nebulizer were dispensed to the patient and *provide* a signed receipt of delivery or member attestation that the device was received with documentation supporting the initial order of the device and drug.

Georgia Medicaid considers the replacement of an Altera Nebulizer System medically necessary only to administer aztreonam inhalation solution (Cayston) when the member has diagnosis of cystic fibrosis, **and** the member has a lung infection with a positive culture demonstrating Pseudomonas aeruginosa infection. The FDA-approved labeling for Cayston states that it should only be administered with the Altera Nebulizer System.

**Coverage Guidelines:**

A replacement Altera Nebulizer System and/or handset will be considered for coverage if the member meets all the following criteria:

a) The initial order for Cayston and the initial Altera Nebulizer was not dispensed within the previous twenty-four (24) months (delivery ticket or member attestation required).

b) The member has a diagnosis of Cystic Fibrosis with pulmonary manifestations with Pseudomonas Aeurginosa:

- Cystic Fibrosis with pulmonary manifestations (On or before 09/30/2015 report ICD-9-CM code 277.02; on or after October 1, 2015, report ICD-10 CM code E84.0)

AND

- Pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere (On or before 09/30/2015 report ICD-9-CM code 041.7; On or after 10/01/2015 report ICD-10-CM code B96.5)

c) The physician's order indicates that a replacement Altera Nebulizer System and/or Handset are medically necessary to delivery Cayston.

**Coding Guidelines:**

An Altera nebulizer or component of the nebulizer requires prior approval to be considered for coverage.

**E0574 U1** - REPLACEMENT ONLY, ALTERA NEBULIZER SYSTEM FOR USE WITH CAYSTON

**E0574 U2** - REPLACEMENT ONLY, ALTERA NEBULIZER HANDSET FOR USE WITH CAYSTON

**Limitations:**

- Altera Nebulizers are noncovered if billed for members who do not have cystic fibrosis with a positive culture demonstrating Pseudomonas aeruginosa infection.
- Altera Nebulizers are only allowed once per two (2) years beginning two (2) years after the initial order for Cayston with the Altera Nebulizer are dispensed.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112.6 | High Frequency Chest Wall Oscillation Devices (Rev. 04/14, 04/15) |
|---|---|

High frequency chest wall devices consist of a vest and tubes that connect the vest to an air-pulse generator that provides oscillations with adjustable intensity and duration. This type of therapy treats members who suffer from excessive bronchial secretions due to cystic fibrosis and other lung diseases in order to prevent airway obstructions.

**Coverage Guidelines:**

High frequency chest wall oscillation devices will be reviewed for coverage of in-home use through the approval process, on a case-by-case basis, for members between the ages of three (3) years through twenty-one (21) years**.**

If approved, the initial coverage period will be based on a three (3) month trial period. Supporting documentation for approval of the remaining rental period (seven (7) months remaining until the device is owned by the member upon reimbursement of the tenth (10) rental month) must demonstrate continued medical need, significant improvement of symptoms in the condition requiring use of the device, no hospital admissions or absenteeism from school related to the supporting diagnosis, consistent compliance with physician's order for therapy, and other information that supports the medical necessity of the device may be submitted.

Coverage will be considered for members who meet the following criteria:

a) There is well-documented failure of standard chest physical therapy treatments to adequately mobilize retained secretions; AND

b) One of the following diagnoses has been confirmed:

    1) Amyotrophic Lateral Sclerosis (ALS)
    2) Cystic Fibrosis
    3) Bronchiectasis
        - Characterized by daily productive cough for at least six (6) continuous months or frequent exacerbations (more than two (2) per year) requiring antibiotic therapy, AND
        - Confirmed by high resolution spiral CT scan

c) Other diagnoses that will be considered on a case-by-case basis include:

    1) Primary Ciliary Dyskinesia
    2) Neurologic Dysfunction with Secondary Pneumonias

**Coding Guidelines:**

Suppliers must request a prior authorization for a high frequency chest wall oscillation device or replacement components to be considered for coverage. HFCWO devices are only reimbursed as a monthly rental and will cap after ten (10) rental months have been reimbursed and will then be considered member owned. Replacement components will not be reimbursed until the device is considered to be member owned.

**E0483** – HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES HOSES AND VEST), EACH

**Replacement Components:**

**A7025-** HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH

**A7026-** HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH

**Limitations:**

- HFCWO devices are noncovered for members over twenty-one (21) years of age.
- Continued coverage beyond the three (3) month trial period is noncovered for members who do not have continued need or who do not comply with usage and therapy as ordered by the physician.
- Rentals may not exceed ten (10) months at which time the device is considered member owned.
- Replacement vests or hoses are not covered during an active rental period. The device must be owned by the member before these items are covered.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112.7 | Intrapulmonary Percussive Ventilator (IPV) (Implemented 02/15, Rev. 04/15) |
|---|---|

An intrapulmonary percussive ventilator (IPV) is a mechanical form of chest physical therapy. This device replaces the manual chest physical therapy that involves clapping or slapping of the member's chest wall. The IPV delivers mini bursts (more than two hundred (200) per minute) of respiratory gasses into the lungs via a mouthpiece. This device is intended to treat active pulmonary disease and prevent the development of disease caused by secretion retention by mobilizing endobronchial secretions and diffusing patchy atelectasis. The member controls variables of the device such as peak pressure, inspiratory time, and the rate of delivery.

**Coverage Guidelines:**

IPV devices are rarely medically necessary in the home as they most often considered institutional equipment, and there is little scientific evidence or medical literature of the benefit of the device used in the home but will be considered on a case-by-case basis through the prior authorization process for members under the age of twenty-one (21) who would otherwise remain hospitalized due to an active pulmonary disease, and have been successfully using he device while admitted.

**Reimbursement Guidelines:**

Coverage of an IPV will be considered if the member meets at least ALL of the following criteria:

a) The member has demonstrated success using an IPV device while admitted to the hospital to treat an active pulmonary disease or to prevent the development of disease caused by secretion retention; AND

b) The member will require the use of the device for no less than ten (10) months during which time the device is expected to eliminate readmission for the supporting diagnosis.

c) The member or caregiver has the ability to operate the device in absence of clinical support, and the member is willing to comply with ordered use of the device.

d) The member has a documented diagnosis of one of the following:

    1) Mechanically ventilated members with Atelectasis
    2) Bronchitis and Bronchiectasis
    3) Bronchopneumonia
    4) Chronic Obstructive Pulmonary Disease
    5) Cystic Fibrosis
    6) Neuromuscular Disorders with Pulmonary Symptoms
    7) Restrictive Lung Disease with Recurrent Atelectasis
    8) Artificial Airways (members who are unable to maintain clear lungs)

An intrapulmonary percussive ventilator (IPV) is covered as purchase once per three (3) years if the medical need still exists, and all policy guidelines are met. The device will be required to meet all initial coverage criteria to be considered for replacement.

**Coding Guidelines:**

An intrapulmonary percussive ventilator (IPV) requires prior approval to be considered for coverage.

**E0481 NU** - INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES

**E0481 U**1 - REPLACEMENT BREATHING CIRCUIT FOR MEMBER OWNED IPV

Limitations:

- IPV devices will not be replaced more than once per three (3) years.
- IPV coverage is limited to members who are less than twenty-one (21) years of age.
- Breathing circuits are included in the initial purchase of the device and will not be replaced more than once (1) per six (6) months once the device is considered to be member owned.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112.8 | Mechanical In-exsufflation Device (Cough Stimulating Device) (Rev. 04/15) |
|---|---|

A mechanical in-exsufflation (cough stimulating) device is used to assist coughing by inflating the lungs with positive pressure, followed by rapidly applied negative pressure during expiration. The device is electronic and portable and is indicated for members with neuromuscular diseases who have the inability to sufficiently cough.

**Coverage Guidelines:**

Coverage of a mechanical in-exsufflation (cough stimulating device) will be considered for members who meet both of the following criteria:

a) The member has been diagnoses with a neuromuscular disease (see Diagnoses Supporting Medical Necessity), AND

b) The condition causes a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained respiratory secretions

**Diagnoses Supporting Medical Necessity:**

Providers are reminded that ICD-9-CM codes must be reported on or before 09/30/2015 and ICD-10-CM must be reported on or after 10/01/2015.

| ICD-9-CM | ICD-10-CM | Code Description |
|---|---|---|
| 138 | B91, G14 | LATE EFFECTS OF ACUTE POLIOMYELITIS |
| 335.0-335.9 | G12.0-G12.9 | WEDNIG-HOFFMAN DISEASE - ANTERIOR HORN CELL DISEASE |
| 340 | G35 | MULTIPLE SCLEROSIS |
| 344.00-344.09 | G82.50-G82.54 | QUADRIPLEGIA |
| 355.20 | G12.21 | AMYOTROPHIC LATERAL SCLEROSIS (ALS) |
| 359.0 | G71.2 | CONGENITAL HEREDITARY MUSCULAR DYSTROPHY |
| 359.1 | G72.9 | HEREDITARY PROGRESSIVE MUSCULAR DYSTROPHY |
| 359.21 | G71.11 | MYOTONIC MUSCULAR DYSTROPHY |
| 359.71 | G72.41 | INCLUSION BODY MYOSITIS |

**Coding Guidelines:**

A mechanical in-exsufflation (cough stimulating) device requires prior approval to be considered for coverage. The devices are only reimbursed as a capped rental and are considered member owned after ten (10) rentals have been reimbursed.

**E0482**- COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE

**Supplies:**

Supply code A7020 is for replacement only and may not be billed on initial issue of the device. One (1) replacement interface will be allowed per month beginning with the second rental month and will continue for the duration of need. Orders for supplies may not exceed a twelve (12) month period and must indicate that the device is still in use and medically necessary.

**A7020-** INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY

**Limitations:**

- Mechanical in-exsufflation devices are limited to one purchase (ten (10) rentals = purchase), per five years.
- Supplies billed with the initial rental of the device are noncovered.
- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1112.9 | Oxygen and Oxygen Related Equipment (Rev. 10/14, 04/15, 10/22) |
|---|---|

Oxygen and oxygen related equipment are devices and supplies that provide controlled oxygen concentrations and flow rates to members who cannot otherwise maintain adequate tissue and cell oxygenation. Oxygen levels are measured by testing the arterial blood (ABG – Arterial Blood Gas) and assessing the oxygen level in the blood (Pa02) which can determine the medical necessity of oxygen therapy. Another testing method is pulse oximetry which measures the saturation level of oxygen in the blood ("sat" or Sa02). These devices clip on to part of the body (ear, finger, toe, etc.) and read the oxygen saturation in the blood by light beams. Although SaO2 and PaO2 are different tests with independent readings, they provide similar information that provides sufficient evidence to make a clinical determination in the appropriateness of supplemental services.

**Coverage Guidelines:**

(NCD 240.2 for Home Use of Oxygen)

Medicaid coverage of home oxygen and oxygen related equipment under the durable medical equipment (DME) benefit is considered reasonable and necessary only for members with lung –related diseases or cardiac conditions causing significant hypoxemia who meet the required coverage criteria for medical documentation, laboratory evidence, and health conditions specified in this policy.

**For both groups I and II**, there must be a physician's certification of medical necessity for oxygen equipment which must include the results of specific testing before coverage can be determined. Requests for prior approval of oxygen therapy must also be supported by medical documentation in the member's record. This documentation may be in the form of a prescription written by the patient's attending physician who has recently examined the patient (normally within a month of the start of therapy) and must specify:

a) **Written order/CMN including:**

1) A diagnosis of the disease requiring home use of oxygen;
2) The oxygen flow rate; and
3) An estimate of the frequency, duration of use (e.g., 2 liters per minute, 10 minutes per hour, 12 hours per day), and duration of need (e.g., 6 months or lifetime).
4) **NOTE:** Liquid Oxygen also requires a separate letter documented by the physician that includes activities performed for at least four (4) or more hours a day (school, work, etc.) that supports the need for this type of oxygen therapy. The prescribing physician must list the number hours the oxygen is considered reasonable and necessary

**There must also be on file:**

b) **An attestation** (signed statement by member or caregiver) issued at the time of delivery, indicating that the member has been educated in the dangers of

smoking and that there will be no smoking while equipment is in use. This documentation may be in the form of information contained on the delivery ticket, an environmental check list, or separate attestation form.

c) **Qualifying test results** must be kept on file for no less than six (6) years.

**Group I (12 months) Coverage Criteria:**

Coverage of oxygen equipment for in-home use will be considered for twelve (12) months for members with significant hypoxemia who meet one of the following criteria:

1) An arterial $PO_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken at rest, breathing room air.

2) An arterial $PO_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during sleep for a patient who demonstrates an arterial $PO_2$ at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake; or a greater than normal fall in oxygen level during sleep (a decrease in arterial $PO_2$ more than 10 mm Hg, or decrease in arterial oxygen saturation more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for use of oxygen during sleep, and then only one type of unit will be covered. **Portable oxygen, therefore, would not be covered in this situation.**

3) An arterial $PO_2$ at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during exercise for a patient who demonstrates an arterial $PO_2$ at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

**Group II (3 months) Coverage Criteria**:

Coverage of oxygen equipment for in-home use will be considered for three (3) months for members whose arterial $PO_2$ is 56-59 mm Hg or whose arterial blood oxygen saturation is 89% if there is evidence of any of the following:

1) Dependent edema suggesting heart failure;
2) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale on EKG (P wave greater than 3 mm in standard leads II, III or AVFL;

   **or**
3) Erythrocythemia with a hematocrit greater than 56%.

**Portable Oxygen Coverage:**

Portable oxygen, for the reimbursement, may be liquid or gaseous. Portable oxygen may be considered medically necessary for physician visits or other situations in which the member does not have access to a stationary oxygen system. Only one unit of

service is reimbursed per month regardless of the number of tanks provided as this is based on medical necessity. A home-fill system (K0738) or portable oxygen concentrator (E1392) is billed in conjunction with the concentrator (E1390) when they are considered medically necessary and approved through the prior approval process.

**Supplemental Oxygen Therapy:**

Under limited circumstances, on a case-by-case basis, the Department will review the use of supplemental oxygen for members with a blood gas study that exceeds qualifying coverage criteria for PO 2 and pulse oximetry saturations. In this case, documentation from the physician must include sufficient information to support the medical necessity for supplemental oxygen therapy. Members under twenty-one (21) years of age are reviewed for medical necessity based on information submitted by the pediatric specialist specific to the needs of the pediatric population, and the specific pediatric diagnosis. The Department may request a consultation from a pulmonologist and/or additional lab studies.

Conditions for which oxygen therapy may be covered:

a) A severe lung disease such as:

- Chronic Obstructive Pulmonary Disease
- Diffuse Interstitial Lung Disease, whether known or unknown etiology
- Cystic Fibrosis
- Bronchiectasis
- Widespread Pulmonary Neoplasm; or

b) Hypoxemia related symptoms or findings that might be expected to improve with oxygen therapy. Examples of these findings are:

- Pulmonary Hypertension
- Recurring Congestive Heart Failure due to Chronic Cor Pulmonale
- Erythrocytosis,
- Impairment of the cognitive process
- Nocturnal Restlessness
- Morning Headache.

c) Tracheostomy dependent members under the age of twenty-one (21) years.

**Initial Certification:**

All initial orders for oxygen and oxygen related equipment require a blood gas study or pulse oximetry testing to be submitted with the request for prior approval (short-term use does not have this requirement see testing guidelines below). The blood gas study or pulse oximetry test must be the most recent study obtained within 90 days prior to the order for the oxygen therapy. If a member transitions from a Medicaid HMO to FFS Medicaid, then there is not a requirement for a new blood gas study or pulse oximetry test prior to the initial request for oxygen, but the most recent study must be submitted with the request for prior approval with a new order (CMN) for the services.

**Revised Certification:**

A revised certificate of medical necessity requires new medical documentation that supports the requested change in services. This documentation must reflect that there has been a change in the member's condition that affects the need for or change in oxygen and oxygen related equipment. A new prior authorization is required. Providers that have an active prior authorization should request that the existing authorization be ended when they are requesting the revised service so that there is not an inappropriate denial for same or similar services.

**Recertification:**

Recertification CMNs do not require repeat testing. The results from the initial qualifying blood gas study or oximetry test may be used on the Recertification CMN as long as the physician completing the order agrees that the oxygen therapy is improving or stabilizing the condition for which the oxygen is required and the medical need for the services still exists. The treating physician should see and re-evaluate the patient within 90 days prior to the recertification.

**Testing Guidelines:**

$PO_2$ blood tests must be done by a physician, hospital, or a lab. Overnight Oximetry studies may be performed in the home and the data may be submitted to an independent diagnostic testing facility (IDTF) and sent directly to the physician for initial certification of oxygen. $PO_2$ and Oximetry studies are to be done on room air with the member at rest and be submitted with the PA request.

Other conditions under which laboratory tests are performed must be specified, (e.g., on oxygen). If the test values do not qualify; however, are a lower-than-normal value, and the member cannot be tested while breathing room air, supporting documentation is required from the physician.

**Reimbursement Guidelines:**

Oxygen and oxygen related equipment are rented indefinitely for as long as the equipment is medically and necessary, and there is a valid prior authorization on file, however, the reimbursement of an item that is rented continuously includes all related supplies (tubing, probes, masks, etc.)

**Coding Guidelines:**

Oxygen and oxygen related equipment require prior approval to be considered for coverage. These devices are reimbursed as an indefinite rental for as long as it is considered to be medically necessary. Supplies are not separately reimbursed as they are included the rental reimbursement.

**E0431** - PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING

**E0433** - PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUEFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER

**E0434** - PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING

**E0439** - STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING

**E0441** - STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT

**E0442** - STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT

**E1390** - OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE

**E1392** - PORTABLE OXYGEN CONCENTRATOR, RENTAL

**K0738 -** PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS; INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING

**Limitations:**

- Intermittent and P.R.N (as needed) oxygen is non-covered.
- Oxygen therapy is noncovered for angina pectoris in the absence of hypoxemia.
- Oxygen therapy is noncovered for breathlessness without cor pulmonale or evidence of hypoxemia. Although intermittent oxygen is sometimes prescribed to relieve this condition, it is potentially harmful and psychologically addicting.
- Oxygen therapy is noncovered for severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO2 improves the oxygenation of tissues with impaired circulation.
- Oxygen therapy is noncovered for diagnoses of terminal illnesses that do not affect the lungs.
- Only one type of stationary oxygen system (liquid or gas) will be reimbursed during the same rental month.
- A pulse oximeter (E0445) and apnea monitor (E0619) are not covered during the same billing period (month).
- Oxygen and oxygen related equipment will be considered noncovered if all policy specific guidelines are not met.
- Oxygen and oxygen related equipment will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule of Maximum Allowable Payments (SMAP).

| POLICY 1112.10 | Ventilators (Rev. 10/12, 04/13, 10/13, 01/14, 04/15, 01/16) |
|---|---|

Home ventilators are life sustaining devices that are generally used to transition members from fully assisted critical care mechanical ventilation to normal respiration of room air. Typically, the member initiates spontaneous breathing activity that is machine assisted by volume pressure and control. A backup rate feature sounds an alarm should the member become unable to initiate breathing and the machine then automatically takes over breathing functions until the member is capable of resuming spontaneous breathing activity. This type of device may be appropriate for in-home use if the environmental settings are favorable, and the member or caregiver has the ability to use the device safely and effectively.

**Coverage Guidelines:**

Institutional equipment is not covered by Georgia Medicaid as a DME benefit for in-home use. Provisions may be made to consider the rental of volume ventilators or therapeutic ventilators (i.e., BIPAP ST- SEE Policy 1112.3) that are considered appropriate and adaptable for in-home use should it be determined that it is more prudent than institutional placement of the member.

In-home use of a ventilator will be considered for members who meet the following criteria are met and sufficient documentation is submitted with the request for prior authorization including, but not limited to:

1) A detailed written order from the member's ordering physician including the type of equipment ordered, the length of need, and a qualifying diagnosis (see # 2);
2) The member has a documented diagnosis of one of the following:
    - Neuromuscular disease
    - Thoracic restrictive disease
    - Chronic respiratory failure consequent to chronic obstructive pulmonary disease
3) A copy of the member's history and physical examination from the ordering physician;
4) The member was an inpatient for at least fourteen (14) consecutive days prior to home ventilation;
5) The member is dependent on a ventilator for life support for at least six (6) hours per day;
6) The home ventilator replaces the need for inpatient respiratory cares services that would be reimbursed by Medicaid;
7) The member has adequate support services or caregiver which would allow sufficient use of the ventilator in the home;
    a) A check list documenting the members environment from the vendor;
    b) A comprehensive list of all items required for the member to use the home ventilator (i.e., back-up unit, suction equipment, and supplies);

c) The member receives services under the direction of a pulmonary physician who is familiar with the technical and medical components of home ventilator support and has determined that in-home care is safe and feasible for the member.

If the provider is unable to obtain a family and social history from the hospital, then a vendor generated report documenting family and social history may be submitted. The report must be completed and signed by qualified personnel (i.e., social worker and/or certified respiratory technician (RT). A certified respiratory technician (RT) is responsible for equipment set up, training/education on the proper usage of the equipment and monthly visits to the home for all ventilators in this policy.

If this information is not included in the documentation submitted during the request for prior authorization, then the request will be denied for missing information.

**Pressure Support Ventilators (E0465 or E0466):**

A pressure support ventilator with pressure control (E0465) for use with an invasive interface (tracheostomy tube [i.e., LTV950] and E0466 for use without invasive interface (mask) is covered for infants and small children on a case-by-case basis and is considered to be a continuous rental for the duration of medical necessity as indicated by renewal of the prior authorization with the treating physician's request for continued services. Additional information to justify the need for this type of in-home ventilator must be submitted. In limited cases, when medical necessity has been established, E0466 may be considered for coverage for children up to twenty (21) years of age. Members over twenty-one (21) years age will be reviewed on a case-by-case basis only.

**Reimbursement Guidelines:**

Home ventilators are considered to be indefinite rentals that are rented for duration of medical necessity and include all associated supplies that are required for appropriate use of the device and are not separately reimbursed. Servicing, repairs, and labor are also included in the monthly rental fee and may not be submitted for separate reimbursement.

A resuscitation bag (S8999) may be requested for members requiring artificial respiration equipment for use during power failure or other catastrophic events. The flutter device (S8185) and the precursor device (E0480) may be requested separately for lung conditions that require the loosening of mucous plugs and congestion.

**Coding Guidelines:**

Ventilators require prior approval to be considered for coverage. The initial approval is limited to maximum of 6-months, and a maximum of 12-months thereafter. These devices are reimbursed as an indefinite rental for as long as it is considered to be medically necessary. Supplies are not separately reimbursed as they are included the rental reimbursement.

**E0465-** HOME VENTILATOR, ANY TYPE, USED WITH INVASIVE INTERFACE, (E.G., TRACHEOSTOMY TUBE)

**E0466-** HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE, (E.G. MASK, CHEST WALL)

Ventilators may not be billed using codes for CPAP (E0601) or bi-level PAP (E0470 or E0471) even if the ventilator is only being used in CPAP or BIPAP mode. If the ventilator is only intended for use in CPAP or BIPAP mode, then the physician must order that equipment (Refer to policy 1112.3 for CPAP/BIPAP guidelines).

**Limitations:**

- Home ventilators will be considered noncovered if all policy specific guidelines are not met.
- Home ventilators will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Only one device will be covered per the billing period as indicated on the Schedule of Maximum Allowable Payments (SMAP).
- All supplies, maintenance, labor, and repair fees are included in the monthly rental fee for items considered “indefinite rentals.

| POLICY 1112.11 | Pulse Oximeters (Rev.10/20, 4/21,10/22) |
|---|---|

Coverage will be considered for a pulse oximeter (E0445) for members less than twenty (21) years of age who have been approved for oxygen therapy services.

Providers must request a prior authorization and submit a written letter of medical necessity (LOMN) for a pulse oximeter to be considered for coverage. A pulse oximeter for home use will be considered medically necessary for members with chronic lung disease, severe cardiopulmonary disease or neuromuscular disease involving muscles of respiration, or **any** of the following indications:

a) Tracheostomy dependent patients who can breathe room air.
b) To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep
c) To monitor individuals on a ventilator at home.
d) Monitoring for changes in a member’s physical condition that requires a physician-directed adjustment in the liter flow of their home oxygen needs.
e) When weaning a member from home oxygen.
f) For interstage monitoring of children undergoing the Norwood procedure for hypoplastic left heart syndrome.

The physician must document the saturation readings and maintain this information in the members’ medical record.

**Note:** A pulse oximeter and supplemental oxygen will be considered for coverage for medically fragile members who are tracheostomy dependent and who breath room air up to the age of twenty-one (21) years.

**Continuous Pulse Oximeter**

A continuous pulse oximeter for home use will be consider medically necessary for the following indications:

- To monitor members on a home ventilator with an invasive interface (E0465) when the ventilator does not have a built-in pulse oximeter; **or**
- To monitor home care members with tracheostomies; **or**
- To monitor members less than two (2) years of age with bronchopulmonary dysplasia; **or**
- To monitor members with spinal muscular atrophy or congenital central hypoventilation syndrome; **or**
- To monitor members with a medical need to maintain oxygen saturation within a very narrow range; **or**
- The member would otherwise require hospitalization solely for the purpose of continuous monitoring

  **AND**

- Continuous pulse oximetry performed in the home is covered only when **ALL** the following indications are present:
  - The member would otherwise require hospitalization solely for the purpose of continuous monitoring
  - The results are reliable in the home setting
  - The member's record documents that the oximeter is preset and self-sealed and cannot be adjusted by the member or caregiver
  - The device is able to provide a printout which documents an adequate number of sampling hours (a minimum of eight hours should be recorded), percent of oxygen saturation and an aggregate of the results (this information must be available if requested)
  - A trained caregiver is available to respond to changes in the oxygen saturation.

**Intermittent Pulse Oximeter**

Intermittent pulse oximeter monitoring (less than 24 hours) for home use may be considered medically necessary for the following indications:

- To evaluate initial and ongoing medical necessity of an oxygen therapeutic regimen; **or**
- To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep; **or**
- To evaluate change in a member's condition requiring an adjustment to the liter flow of home oxygen; **or**
- To monitor changes in a member's physical condition that requires a physician-directed adjustment in the liter flow of their home oxygen needs; **or**
- For infants less than one year of age using home oxygen; **or**
- For interstage monitoring of children undergoing the Norwood procedure for hypoplastic left heart syndrome; **or**
- When weaning a member off home oxygen.

A pulse oximeter for home use (intermittent or continuous) is considered not medically necessary when used for indications other than those listed above including, but not limited to, asthma management or when used alone as a screening/testing technique for suspected obstructive sleep apnea (OSA).

**Coding Guidelines:**

Continuous Pulse Oximeter

The pulse oximeter provided must be new and have a manufacturer's warranty. The provider is responsible for training on the proper use of the equipment and related supplies. This device is reimbursed as a monthly rental for a capped period of up to ten (10) months. Once ten (10) rentals have been reimbursed the device will be considered as member owned. Either an apnea monitor, or a pulse oximeter will be covered, but not both. If both devices are submitted for approval, then the medical necessity is determined through the prior approval process. Probes (non-disposable) are included in the purchase of the pulse oximeter and must be dispensed as ordered.

**E0445 RR -** OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NONINVASIVELY

Intermittent Pulse Oximeter

The intermittent pulse oximeter provided must be new and have a manufacturer's warranty. The provider is responsible for training on the proper use of the equipment and related supplies. This device will be covered as a purchase only if all policy guidelines are met.

**E0445 NU -** OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NONINVASIVELY

Oxygen Probes

Oxygen probes do not require prior authorization and will only be covered for members under the age of twenty-one (21) years. Probes may be billed separately for use with an approved prior authorization for a Continuous Pulse Oximeter (E0445 RR).

- Disposable Oxygen Probes: Only four (4) disposable oxygen probes will be covered per month as indicated on the SMAP.

  **A4606 -** OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, [DISPOSABLE]

- Reusable Oxygen Probes: Only one (1) reusable oxygen probes will be covered per year as indicated on the SMAP.

  **A4606 NU -** OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, [REUSABLE]

- Oxygen Probe (Replacement Only): Any requests for additional oxygen probes which exceed the maximum allowed units published on the SMAP will be considered for coverage on a case-by-case basis.

  **A4606 U1 -** OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT

**Limitations:**

- The member is over twenty-one (21) years of age
- The device will be considered noncovered if all policy specific guidelines are not met.
- The device will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- A pulse oximeter (E0445) and apnea monitor (E0619) are not covered during the same billing period (month).
- Only one (1) continuous pulse oximeter device will be covered per five (5) years. If less than five (5) years, rationale as to the lesser lifetime must be provided.
- Only one (1) intermittent pulse oximeter device will be covered per two (2) years. If less than two (2) years, then a rationale as to the lesser lifetime must be provided.
- Only one type of oxygen probe (disposable or reusable) will be covered per billing period.
- Only four (4) disposable probes will be covered per month without prior approval.
- Only one (1) reusable probe will be covered per one (1) year without prior approval.

| POLICY 1113 | Suction Pumps and Supplies/ Wound Care |
|---|---|

Suction pumps and supplies are devices that are used to aid in the removal of respiratory secretions through oral pharyngeal and tracheal suction or to remove exudate, debris, and promote the healing of qualifying wounds in the home setting.

| POLICY 1113.1 | Negative Pressure Wound Therapy Devices (Rev. 04/13, 07/13, 04/15) |
|---|---|

Negative pressure wound therapy devices are used in the treatment of acute and chronic wounds that require the application of sub atmospheric pressure to remove exudate and debris from the wound to promote healing. Negative Pressure wound therapy is delivered through an integrated system of a suction pump, a separate exudate collection chamber and the appropriate dressing sets for qualifying wounds. In these systems, exudate is completely removed from the wound site to the collection chamber.

Negative pressure wound therapy devices must have the capability of treating multiple wounds, but only one unit is utilized and reimbursed by Medicaid. These devices are only considered a DME benefit for member's who require in-home use of the device.

**Provider Requirements:**

Providers who supply NPWT devices must:

- Have qualified knowledgeable staff who are available to trouble shoot equipment at all times (on call after hours)
- Have a repair center and employ qualified repair technicians
- Provide high quality devices with a standard (12 month) warranty that are expected to last the duration of the reasonable useful lifetime
- Must repair equipment throughout the reasonable useful lifetime
- Must use accredited Home Health Agencies with Certified Wound Care experts
- The DME wound care equipment provider must collaborate with the certified wound care expert to recommend the appropriate equipment after the assessment

**Coverage Guidelines:**

A Negative Pressure Wound Therapy pump (E2402) and related supplies (A6550, A7000) will be considered for coverage for up to three (3) rental months in the home setting for members who are under the age of twenty-one (21), who have a chronic Stage III or IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer or a chronic (present for at least thirty (30) days) ulcer of mixed etiology. A complete wound therapy program described by criterion1 and one of criteria 2, 3, or 4, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to the request for coverage of NPWT.

1) For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should

either be addressed, applied, or considered and ruled out prior to the application of NPWT:

a) Documentation in the member's medical record of evaluation, care and wound measurements by a licensed medical professional, and
b) Application of dressings to maintain a moist wound environment, and
c) Debridement of necrotic tissue if present, and
d) Evaluation and provision for adequate nutritional status

2) For Stage III or IV pressure ulcers:

a) The member has been appropriately turned and positioned, and
b) The member has used a covered support surface for pressure ulcers on the posterior trunk or pelvis, and
c) The member's moisture and incontinence has been appropriately managed

3) For neuropathic (i.e., diabetic) ulcers:

a) The member has been on a comprehensive diabetic management program, and
b) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities

4) For venous insufficiency ulcers:

a) Compression bandages and/or garments have been consistently applied, and
b) Leg elevation and ambulation have been encouraged

**Initial coverage:**

In addition to the criteria above (1 and one of 2, 3 or 4), the following documentation must be submitted with the request for prior approval (initial and recertification requests)

a) A detailed written order signed and dated by the treating physician documenting the equipment ordered, the length of need, and the diagnosis supporting the medical necessity of the device.
b) Documentation describing the wound(s) that includes the occurrence date, location, type/stage, measurements, quantity of exudates, presence of granulation and necrotic tissue, presence of tunneling if applicable.
c) Documentation of current wound management and previous treatment regimens including type of dressings utilized and frequency of changes.
d) Measures that are being addressed such as debridement, nutritional concerns, support surfaces, positioning, incontinence control, diabetes management, etc.

**Continued Coverage:**

After the initial three months of coverage have been exhausted, coverage will be determined on a monthly basis through the prior authorization process. The request for continued coverage must include:

a) A recent assessment by the treating physician that includes updated wound measurements, healing progress, and other wound characteristics
b) Therapy exceeding three months of coverage requires additional documentation supporting the medical necessity of the device and may include wound clinic notes and any assessments performed by a certified wound care professional including any of the following:

- Licensed Physical Therapist (PT)
- Enterostomal and Treatment Nurse (ET)
- Certified Wound, Ostomy and Continence Nurse (CWOCN)
- Certified Wound Care Nurse (CWCN)
- Certified Wound Ostomy Nurse (CWON)

Wounds must be assessed monthly to certify that the device remains medically necessary.

**Coding Guidelines:**

Negative pressure wound therapy devices require prior approval to be considered for coverage. These devices are reimbursed only as a monthly rental, and supplies may be reported separately. Negative pressure wound therapy devices are rented for the duration of medical necessity.

**E2402-** NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE

**Supplies:**

**A6550 -** WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES

**A7000 -** CANISTER, DISPOSABLE, USED WITH SUCTION PUMP, EACH

**Limitations:**

Negative pressure wound therapy devices are noncovered for if any of the following applies (1-4):

1) The member is over twenty-one (21) years of age;
2) Presence in the wound of necrotic tissue with eschar if debridement is not attempted;
3) Osteomyelitis within the vicinity of the wound that is not concurrently being treated with intent to cure;
4) Cancer is present in the wound;
5) Presence of an open fistula to an organ or body cavity within the vicinity of the wound.
6) NPWT devices are limited to ten (10) rental months and will then be considered member owned.
7) NPWT will be considered noncovered if all policy specific guidelines are not met.

8) NPWT devices and supplies will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
9) Only one device and limited supplies will be covered per month as indicated on the Schedule of Maximum Allowable Payments (SMAP).

| POLICY 1113.2 | Respiratory Suction Pumps (Rev. 04/13, 07/15) |
|---|---|

A respiratory suction pump is an electrical aspirator that is designed for upper respiratory oral pharyngeal and tracheal suction for use in the member's home. Respiratory suction pumps remove respiratory secretions that cannot be managed by the member due to a compromised cough mechanism or tracheostomy.

**Coverage Guidelines:**

A respiratory suction pump will be considered for coverage if the following the member has difficulty raising and clearing secretions secondary to one of the following:

a) Cancer or surgery of the throat or mouth
b) Dysfunction of the swallowing muscles
c) Unconsciousness or obtunded state
d) Tracheostomy

Supplies are considered to be included in the rental fee during the ten (10) month rental period.

**Coding Guidelines:**

Suction pumps require prior approval to be considered for coverage, and these devices are approved on a case-by-case basis. These devices are reimbursed as a monthly rental for a capped period of up to ten (10) months. Once ten (10) rentals have been reimbursed the device is considered to be member owned.

**E0600 RR -** RESPIRATORY SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC

**Supplies:**

Supplies may be billed separately for use with an approved respiratory suction pump **after** the device is considered to be owned by the member (not during the ten (10) month rental period)**.** Additionally, A4605 and A4624 are only covered for use with a member owned respiratory suction pump for members with a tracheostomy.

**A4217** - STERILE WATER/SALINE, 500 ML

**A4605** - TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH

**A4624** - TRACHEAL SUCTION CATHETER, ANY TYPE OTHER THAN CLOSED SYSTEM, EACH

**A4628** - OROPHARYNGEAL SUCTION CATHETER, EACH (eff. 04/15)

**A7047** - ORAL INTERFACE USED WITH RESPIRATORY SUCTION PUMP, EACH

**A7000** - CANISTER, DISPOSABLE, USED WITH SUCTION PUMP, EACH

**A7001** - CANISTER, NON-DISPOSABLE, USED WITH SUCTION PUMP, EACH

**A7002** - TUBING, USED WITH SUCTION PUMP, EACH

**Limitations:**

- Respiratory suction pumps are capped rental items that are limited to ten (10) rental reimbursements at which time the device is considered member owned.
- Only one type of suction catheter will be reimbursed per month (as ordered).
- A valid prescription must be on file at all times for all items submitted for prior approval and for all claims submitted whether prior approval is required or not.
- Supplies are not separately reimbursed until the respiratory suction pump is member owned.
- Respiratory suction pumps will be considered noncovered if all policy specific guidelines are not met.
- Respiratory suction pumps will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Equipment and related supplies are covered per the billing period as indicated on the Schedule of Maximum Allowable Payments (SMAP).

| POLICY 1114 | Supplies |
|---|---|

Georgia Medicaid provides coverage for supplies that are medically necessary and have been ordered by the physician treating the condition for which they are required. Supplies are often used in conjunction with base durable medical equipment and are reimbursed on a monthly basis in accordance with the units approved or maximum allowed units published on the DME schedule of maximum allowable payments (SMAP).

| POLICY 1114.1 | Ostomy Supplies (Rev. 01/19) |
|---|---|

Ostomy supplies are considered for coverage, when prior approved, where applicable. The quantity of supplies is determined primarily by the type of ostomy, its location, its construction, and the condition of the skin surface surrounding the ostomy. Providers must refer to the DME Schedule of Maximum Allowable Payments (SMAP) for utilization and prior authorization guidelines.

**Coverage Guidelines:**

Ostomy supplies are considered medically necessary for members who meet the following criteria:

1) The member has a permanent or temporary colostomy, ileostomy or (stoma) other artificial opening to divert urine or fecal contents outside of the body; and
2) The ordering physician has documented the type of supplies required and the estimated length of need (not to exceed twelve (12) months)

**Diagnoses Supporting Medical Necessity:**

Providers are reminded that ICD-9-CM codes must be reported on or before 09/30/2015 and ICD-10-CM must be reported on or after 10/01/2015.

| ICD-9-CM | ICD-10-CM | Code Description |
|---|---|---|
| 569.60 | K94.00 or K94.10 | COLOSTOMY AND ENTEROSTOMY COMPLICATON UNSPECIFIED |
| 569.62 | K94.03 or K94.13 | MECHANICAL COMPLICATION OF COLOSTOMY AND ENTEROSTOMY |
| V44.2 | Z93.2 | ILEOSTOMY STATUS |
| V44.3 | Z93.3 | COLOSTOMY STATUS |
| V44.6 | Z93.6 | STATUS OF OTHER ARTIFICIAL OPENING OF THE URINARY TRACT |
| V55.2 | Z43.2 | ATTENTION TO ILEOSTOMY |
| V55.3 | Z43.3 | ATTENTION TO COLOSTOMY |
| V55.6 | Z43.6 | ATTENTION TO OTHER ARTIFICIAL OPENING OF URINARY TRACT |

**Coding Guidelines:**

Ostomy supplies may or may not require prior approval. Providers should refer to the schedule of maximum allowable payments for durable medical equipment services (DME SMAP) for usual maximum units and prior authorization requirements. Most supplies in this policy do not require prior approval unless the provider is requesting overutilization of the supply, but in some cases prior authorization is required for approval of standard units.

**A4362** - SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT; EACH

**A4364** - ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PER OZ

**A4367** - OSTOMY BELT, EACH

**A4371** - OSTOMY SKIN BARRIER, POWDER, PER OZ

**A4373**- OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITH BUILT-IN CONVEXITY, ANY SIZE, EACH

**A4385** - OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, EACH

**A4388** - OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, (1 PIECE), EACH

**A4389** - OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH

**A4390** - OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT IN CONVEXITY (1 PIECE), EACH

**A4397** - IRRIGATION SUPPLY; SLEEVE, EACH

**A4402** - LUBRICANT, PER OUNCE

**A4404** - OSTOMY RING, EACH

**A4405** - OSTOMY SKIN BARRIER, NON-PECTIN BASED, PASTE, PER OUNCE

**A4407** - OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH

**A4409 -** OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH

**A4414** - OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH

**A4424** - OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH

**A4425** - OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH

**A4427**- OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH

**A4432** - OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FAUCET-TYPE TAP WITH VALVE (2 PIECE), EACH

**A4450** - TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES

**A4455** - ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE), PER OUNCE

**A4456** - ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

**A5052** - OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED (1 PIECE), EACH

**A5054** - OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH

**A5055** - STOMA CAP

**A5061** - OSTOMY POUCH, DRAINABLE; WITH BARRIER ATTACHED, (1 PIECE), EACH

**A5062** - OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER ATTACHED (1 PIECE), EACH

**A5063** - OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH FLANGE (2 PIECE SYSTEM), EACH

**A5071** - OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED (1 PIECE), EACH

**A5073** - OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH

**A5120** - SKIN BARRIER, WIPES OR SWABS, EACH

**A5122** - SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT, EACH

**A5131** - APPLIANCE CLEANER, INCONTINENCE AND OSTOMY APPLIANCES, PER 16 OZ.

**A6216** - GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

**Limitations:**

- Ostomy supplies will be considered noncovered if all policy specific guidelines are not met.
- Ostomy supplies will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Ostomy supplies are covered per the billing period as indicated on the Schedule of Maximum Allowable Payments (SMAP).

| POLICY 1114.2 | Surgical Dressings (Rev. 04/15, 06/16) |
|---|---|

Surgical dressings are supplies that are medically necessary for wound debridement or for the treatment of a wound caused by, or treated by, a surgical procedure, and require a physician's order for use of wound changes in the member's home. These supplies are broken out in to two types of dressings, primary and secondary. Primary surgical dressings are therapeutic or protective coverings that are applied directly to the wound and secondary dressings are used as a protective measure to secure the primary dressing to the wound (i.e., elastic stockings).

**Coverage Guidelines:**

Surgical dressings will be considered for coverage for members who meet the following criteria:

1) The treating physician has ordered surgical dressings that are required for the in-home treatment of a wound caused by, or treated by, a surgical procedure; or
2) They are required for in-home use after the debridement of a wound.
3) The quantity and type of dressing dispensed takes in to account the current status of the wound(s), expected changes, and the recent use of dressings.

Surgical dressings are also covered for use over a percutaneous catheter or tube (e.g., intravascular, epidural, nephrostomy, etc.) as long as the catheter or tube remains in place and after removal until the wound heals.

**SPECIALTY ABSORPTIVE DRESSING (A6251 - A6252)** Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (e.g., Stage III or IV ulcers). Usual specialty absorptive dressing change is up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border. (Eff. 06/16)

**Coding Guidelines:**

Surgical dressings may or may not require prior approval. Providers should refer to the schedule of maximum allowable payments for durable medical equipment services (DME SMAP) for usual maximum units and prior authorization requirements. Most supplies in this policy do not require prior approval unless the provider is requesting overutilization of the supply, but in some cases prior authorization is required for approval of standard units.

Specialty absorptive dressings will require prior authorization effective June 1st, 2016.

**A4450** - TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES

**A4452** - TAPE, WATERPROOF, PER 18 SQUARE INCHES

**A4495** - SURGICAL STOCKINGS THIGH LENGTH, EACH

**A4500** - SURGICAL STOCKINGS BELOW KNEE LENGTH, EACH

**A4510** - SURGICAL STOCKINGS FULL LENGTH, EACH

**A6021** - COLLAGEN DRESSING, STERILE, SIZE 16 SQ. IN. OR LESS, EACH

**A6154** - WOUND POUCH, EACH

**A6196** - DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING

**A6197** - ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING

**A6216** - GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6251**- SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6252** - SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6402** - GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6403** - GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6446** - CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD

Refer to the wound care supplies policy (1114.4) and schedule of maximum allowable payments (DME SMAP) for wound care supplies that may also be covered.

**Limitations:**

- Surgical dressings will be considered noncovered if all policy specific guidelines are not met.
- Specialty absorptive dressings will be denied for members who do not have highly exudative wounds (e.g., Stage III or IV ulcers). (Eff. 06/2016)
- Surgical dressings will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Surgical dressings are covered per the billing period as indicated on the Schedule of Maximum Allowable Payments (SMAP).
- Surgical dressings are noncovered when wound changes are reimbursed as part of another service (home health, etc.) and/or is not performed in the member's community home (typically, POS 12).
- Surgical dressings are noncovered for any of the following situations:
    a) Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure; or
    b) A stage 1 pressure ulcer; or
    c) A first-degree burn; or

d) Wounds caused by trauma which do not require surgical closure or debridement (skin tear or abrasion); or
e) A venipuncture or arterial puncture site (e.g., blood sample) other than the site of an indwelling catheter or needle.

| POLICY 1114.3 | Tracheostomy Supplies (Rev. 04/18) |
|---|---|

Tracheostomy supplies are covered for in-home use for members who have a tracheostomy (surgical procedure to create an opening through the neck into the trachea (windpipe), during which a tube is placed through the opening to provide an airway and to remove secretions from the member's lungs. This tube is called a tracheostomy tube or "trach tub".

A tracheostomy is often performed when the member has one of the following indications:

- There is a large object blocking the airway (choking)
- The member is unable to breathe on their own
- There is an inherited abnormality of the larynx or trachea
- The member has inhaled materials or substances that that swell and block the airway (smoke, toxic gases, steam, etc.)
- Cancer of the neck/throat affecting the ability to breathe
- Paralysis of the muscles that control or affect swallowing
- Severe mouth or neck injuries
- Surgery of the throat or larynx that prevents swallowing and breathing

**Coverage Guidelines:**

Tracheostomy supplies will be considered for coverage for member's who meet the following criteria:

1) The treating physician has ordered tracheostomy supplies for in-home use for maintenance and care of a current tracheostomy; and
2) The written order contains at least the following:
    - Qualifying diagnosis
    - Description and/or HCPCS of items ordered
    - Length of need
3) The member has been discharged to and is living in their own community home.

**Diagnoses Supporting Medical Necessity:**

Providers are reminded that ICD-9-CM codes must be reported on or before 09/30/2015 and ICD-10-CM must be reported on or after 10/01/2015.

| ICD-9-CM | ICD-10-CM | Code Description |
|---|---|---|
| 519.00 | J95.00 | TRACHEOSTOMY COMPLICATION UNSPECIFIED |
| 519.01 | J95.02 | INFECTION OF TRACHEOSTOMY |

| | | |
|---|---|---|
| 519.02 | J95.03 | MECHANICAL COMPLICATION OF TRACHEOSTOMY |
| 519.09 | J95.01, J95.03 J95.04, J95.09 | OTHER TRACHEOSTOMY COMPLICATIONS |
| V44.0 | Z93.0 | TRACHEOSTOMY STATUS |
| V55.0 | Z43.0 | ATTENTION TO TRACHEOSTOMY |

**Coding Guidelines:**

Tracheostomy supplies may or may not require prior approval. Providers should refer to the schedule of maximum allowable payments for durable medical equipment services (DME SMAP) for usual maximum units and prior authorization requirements. Most supplies in this policy do not require prior approval unless the provider is requesting overutilization of the supply, but in some cases prior authorization is required for approval of standard units.

TRACHEOSTOMY CARE KIT FOR **NEW** TRACHEOSTOMY covered under HCPCS code **A4625**:

Tracheostomy care trays are sterile and single use. If the kit is billed, then no separate supplies may be reported during the same 30-day period. They include one or more of the following options:

- Plastic tray, a pair of sterile gloves, pipe cleaners, trach tube brush, cotton tipped applicators, twill tape, basin, a drape (tracheostomy dressing), trach sponges and gauze.

TRACHEOSTOMY CARE KIT FOR **ESTABLISHED** TRACHEOSTOMY covered under HCPCS code **A4629**:

Tracheostomy care trays are sterile and single use. If the kit is billed, then no separate supplies may be reported during the same 30-day period. They include one or more of the following options: trach tube brush, pipe cleaners, cotton tipped applicators, twill tape, and trach sponges. (rev. 04/18)

**A4364** - ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PER OZ

**A4402** - LUBRICANT, PER OUNCE

**A4450** - TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES

**A4452** - TAPE, WATERPROOF, PER 18 SQUARE INCHES

**A4456** - ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

**A4623** - TRACHEOSTOMY, INNER CANNULA

**A4625** - TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTOMY

**A4626** - TRACHEOSTOMY CLEANING BRUSH, EACH

**A4629** - TRACHEOSTOMY CARE KIT FOR ESTABLISHED TRACHEOSTOMY

**A5120** - SKIN BARRIER, WIPES OR SWABS, EACH

**A7520** - TRACHEOSTOMY/LARYNGECTOMY TUBE, NON-CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH

**A7521** - TRACHEOSTOMY/LARYNGECTOMY TUBE, CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH

**A7522** - TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLESS STEEL OR EQUAL (STERILIZABLE AND REUSABLE), EACH

**A7526** - TRACHEOSTOMY TUBE COLLAR/HOLDER, EACH

**Limitations:**

- Tracheostomy supplies will be considered noncovered if all policy specific guidelines are not met.
- Tracheostomy supplies will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Tracheostomy supplies are covered per the billing period as indicated on the Schedule of Maximum Allowable Payments (SMAP) with the exception of overutilization requests approved through the prior approval process for members under twenty-one (21) years of age.

| 1114.3a | **Customized Tracheostomy Supplies** **(Rev. 10/22)** |
|---|---|

Custom trach tubes which require the use of an individualized tube due to a member's particular airway condition will be considered for coverage on a case-by-case basis. A tracheostomy tube will be considered "customized' when the product is made-to-order for members with more challenging airway anatomies or a complex airway disorder which prevent the use of a standard trach tube.

**Coding Guidelines:**

The prior authorization request must include clinical documentation which supports the medical necessity for a custom trach tube. For this item, the provider must use the miscellaneous code as defined below and include the MSRP, primary discount, and net cost on the invoice submitted for review.

**A9999 U1** - MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED [< 21 YEARS OF AGE]

**A9999 U2** - MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED

Note: Only four (4) custom trach tubes will be approved per year for members over the age of twenty-one (21) years; and up to twelve (12) custom tubes per year for members under twenty-one (21) years of age.

**Limitations:**

- Customized tracheostomy tubes will be considered noncovered if all policy specific guidelines are not met.

- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Customized tracheostomy tubes billed in excess of the allowable unit amount indicated in policy and on the SMAP will be denied.

| POLICY 1114.4 | Wound Care Supplies (Rev. 07/13, 04/15) |
|---|---|

Georgia Medicaid provides coverage for a wide range of wound care supplies that are used to treat acute or chronic wounds in the home setting. These supplies are commonly ordered for members with venous pressure (diabetic) ulcers, fistulas, erosion of the skin due to various types of cancer, or other open wounds classified as acute or chronic requiring the use of physician ordered supplies.

**Coverage Guidelines:**

Wound care supplies will be considered for coverage for members who meet the following criteria:

1) The treating physician has ordered wound care supplies for in-home use, for a specified time period, for a wound that is classified as either acute or chronic:
    - Acute wound: Wounds taking less than thirty (30) days for complete healing
    - Chronic wound: Wounds taking more than thirty (30) days for complete healing

The physician must assess the wound for continued medical need at least every six (6) months and write a new order for the necessary supplies not to exceed an additional six months (6) months for chronic wounds. If an acute wound has not healed as expected, the physician must assess the wound and an order for no more than an additional thirty (30) days may be written for supplies. A valid order must be kept on file at all times during which supplies are submitted for reimbursement and made available upon request.

All requests for overutilization must be submitted through the prior approval process and must contain supporting documentation. Overutilization requests may be approved for members under twenty-one (21) years of age only for wound care supplies.

**Coding Guidelines:**

Wound care supplies may or may not require prior approval. Providers should refer to the schedule of maximum allowable payments for durable medical equipment services (DME SMAP) for usual maximum units and prior authorization requirements. Most supplies in this policy do not require prior approval unless the provider is requesting overutilization of the supply, but in some cases prior authorization is required for approval of standard units.

**A4217** - STERILE WATER/SALINE, 500 ML

**A4450** - TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES

**A4452** - TAPE, WATERPROOF, PER 18 SQUARE INCHES

**A5120** - SKIN BARRIER, WIPES OR SWABS, EACH

**A5122** - SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT, EACH

**A6021** - COLLAGEN DRESSING, STERILE, SIZE 16 SQ. IN. OR LESS, EACH

**A6154** - WOUND POUCH, EACH

**A6196** - ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING

**A6197** - DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING

**A6216** - GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6251** - SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6252** - SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6402** - GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6403** - GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING

**A6446** - CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD

**Limitations:**

- Wound care supplies will be considered noncovered if all policy specific guidelines are not met.
- Wound care supplies will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.
- Wound care supplies are covered per the billing period as indicated on the Schedule of Maximum Allowable Payments (SMAP) with the exception of overutilization requests approved through the prior approval process for members under twenty-one (21) years of age.

| POLICY 1115 | Transcutaneous Electrical Nerve Stimulators (TENS) (Rev. 07/13, 01/14, 04/15, 04/18) |
|---|---|

Therapy using an in-home transcutaneous electrical nerve stimulator (TENS) involves the transmission of electrical energy from an external stimulator to the peripheral nervous system via cutaneously placed conductive gel pads. This device is ordered to decrease the member's pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. TENS units usually have a single channel (with two electrodes) or dual channels (with four electrodes). The manner in which this energy, or current, is delivered can vary in frequency, intensity, pulse width, electrode placement and duration. The pulse forms can be exclusively positive or negative (monophasic) or bipolar (biphasic), and the frequency can be controlled.

**Coverage Guidelines:**

A TENS unit may be covered for short-term (limited to thirty (30) days or one (1) rental month) or long-term (limited to six (6) months) in-home use depending on the specific case. Members must meet the policy criteria listed below to be considered for coverage of either short or long-term use of the device.

**Short-Term Coverage Criteria:**

TENS units may be considered for coverage for up to a maximum of thirty (30) days for post-operative pain through the prior authorization process for members who meet the following criteria:

1) The ordering physician has documented that the member has acute post-operative pain requiring the in-home use of a TENS unit for up to thirty (30) days that includes:
    - the date of surgery
    - the nature of the surgery
    - the location and severity of pain
2) The member has been evaluated by the physician within thirty (30) days of the written order and has been discharged to the home setting.
3) The member or caregiver is capable of effectively using the device as ordered.

**Long-Term Coverage Criteria:**

Long-term coverage is initially considered through the prior authorization process for no more than thirty (30) days or one rental month. The initial approval is considered to be a trial period during which the member must be evaluated by the physician and the continued need must be documented and submitted for the remaining four (5) rental months to be considered for coverage. (rev. 04/18)

**Initial request for up to thirty (30) days/one (1) rental month requires:**

1) The ordering physician has documented that the member has chronic intractable pain requiring the in-home use of a TENS unit including:
    - the location of the pain

- the severity of the pain
- the duration of time the member has had the pain
- the presumed etiology of the pain
- prior treatment measures and the results of such treatment

2) The member has been seen by the treating physician within the six (6) months prior to the written order for the TENS unit (note: F2F attestation is required at time or prior approval request).

**Extended rental request for the remaining five (5) rental months requires:**

1) The ordering physician has seen the member face-to-face and has documented that the device remains medically necessary during the trial period.

2) The physician must have documented that the:

    - How often the member used the TENS unit
    - The typical duration of use each time
    - The results (effectiveness of therapy in modulating pain)
    - The member is likely to derive significant therapeutic benefit from continuous use over a long period of time

Transcutaneous electrical nerve stimulation therapy is not covered for diagnosis that does not qualify as post-operate or chronic intractable pain. Examples of non-covered diagnoses include:

- Headache
- Visceral abdominal pain
- Temporomandibular joint (TMJ) pain

**Coding Guidelines:**

A TENS unit requires prior approval to be considered for coverage, and these devices are approved on a case-by-case basis. These devices are reimbursed as a monthly rental for a maximum of up to six (6) months per lifetime. Once six (6) rentals have been reimbursed the device is considered to be member owned. Supplies are not separately billable.

**E0720** - TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION

**E0730** - TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION

**Supplies:**

Supplies are only separately reimbursed for member owned TENS units (after six (6) rentals have been reimbursed). Do not report supplies with a TENS unit that is in an active rental period. Replacement wires (A4557) will be allowed once per twelve (12) months, and A4595 will be allowed one (1) unit per month with a two (2) lead TENS unit or two (2) units per month with a four (4) lead TENS unit. There must be a valid physician's order on file at all times for all supplies submitted for reimbursement.

**A4595** - ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)

**A4557** - LEAD WIRES, (E.G., APNEA MONITOR), PER PAIR

**Reimbursement Guidelines:**

A TENS Unit is limited to six (6) rental months per lifetime. After six (6) rental months has been reimbursed by the Department, the device is considered to be member owned. The first rental month is considered to be a thirty (30) day trial period. The trial period must be monitored and well documented by the physician to determine the effectiveness of the TENS unit in modulating the pain. If the physician determines the device is effective, then up to five (5) additional rental months may be approved, and the provider may continue to bill the device.

Supplies used in conjunction with a TENS unit are not separately reimbursed as they are considered to be included in the rental fee.

**Limitations:**

- TENS units are limited to six (6) monthly rentals per lifetime.
- Supplies are not separately reimbursed with a TENS unit that is being rented.
- A4557 (lead wires) are limited to one (1) unit per twelve (12) months for member owned TENS units only.
- A4595 is limited to one (1) unit per month for member owned two lead TENS units (E0720).
- A4595 is limited to two (2) units per month for member owned four lead TENS units (E0730).
- TENS units will be considered noncovered if all policy specific guidelines are not met.
- TENS units will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

| POLICY 1116 | Urological Supplies (Rev. 04/13, 04/15, 04/16) |
|---|---|

Intermittent catheterization is considered to be an effective in-home bladder management solution for members with incomplete bladder emptying due to idiopathic or neurogenic bladder dysfunction. This type of catheterization has been proven to be safe and effective for in-home use and can be performed by the member or caregiver without the assistance of a medical professional with proper training.

**Coverage Guidelines:**

Intermittent urinary catheterization using a sterile technique is covered when the member requires catheterization, and the member meets one of the following criteria (1-4):

1) The member is immunosuppressed (not all-inclusive)
    - On a regimen of immunosuppressive drugs post-transplant
    - On chemotherapy due to cancer
    - Has acquired immune deficiency syndrome (AIDS)
    - Has a drug-induced such as chronic oral corticosteroid use
2) The member has radiological documentation of vesico-ureteral reflux while on a program or intermittent catheterization.
3) The member is a spina-cord injured female with neurogenic bladder that is pregnant (only covered for duration of pregnancy).
4) The member has had distinct, recurrent urinary tract infections while on a program of clean intermittent catheterization, which has been documented at least twice within the twelve (12) month period prior to the initiation of sterile intermittent catheterization

A urinary tract infection is considered if the member has a urine culture with greater than 10,000 colony forming units of a urinary pathogen AND concurrent presence of one or more of the following signs, symptoms, or laboratory findings:

- Fever (oral temperature >38°C (100.4° F)
- Systemic leukocytosis
- Change in urinary urgency, frequency, or incontinence
- Appearance of new or increased automatic dysreflexia (sweating, bradycardia, elevated blood pressure)
- Physical signs of prostatitis, epididymitis, orchitis
- Pyuria (greater than 5 white blood cells (WBCs) per high powered field
- Systematic leukocytosis

Requests for prior authorization must include copies of cultures, urinalysis results, and documented signs and symptoms. Prior authorization requests must be renewed every twelve (12) months for continued coverage unless the need is short-term which requires the prior authorization to be renewed as needed.

**Coding Guidelines:**

Suppliers must request a prior authorization for urological supplies to be considered for coverage. No more than a one-month supply may be submitted for reimbursement at a time.

**A4217**- STERILE WATER/SALINE, 500 ML

**A4315**- INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE

**A4320**- IRRIGATION TRAY WITH BULB OR PISTON SYRINGE, ANY PURPOSE

**A4349**- MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH

**A4351**- INTERMITTENT URINARY CATHETER; STRAIGHT TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH

**A4352**- INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH

**A4353**- INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES

**A4357**- BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE, EACH

**A4358**- URINARY DRAINAGE BAG, LEG OR ABDOMEN, VINYL, WITH OR WITHOUT TUBE, WITH STRAPS, EACH

**A4360**- DISPOSABLE EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE, WITH PAD AND/OR POUCH, EACH

**A4402**- LUBRICANT, PER OUNCE

**A4450**- TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES

**A4452**- TAPE, WATERPROOF, PER 18 SQUARE INCHES

**A4455**- ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE), PER OUNCE

**A4456**- ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

**Limitations:**

- Prior approval is required every twelve (12) months or sooner depending on the duration of need supported by the clinical documentation and physician’s order.
- Maximum allowed amounts are listed on the SMAP, in limited cases, suppliers may request overutilization for members under twenty-one (21) years of age
- Only one type of catheter will be approved per billing period. If the need or utilization changes providers must obtain new clinical documentation supporting the medical necessity.

- These devices and supplies will be considered noncovered if all policy specific guidelines are not met.
- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

**Other Coverage Guidelines:**

If an intermittent catheter does not suffice, other options can be provided after review of medical documentation. Other Foley catheter types are provided on a case-by-case basis with supporting medical necessity.

**Coding Guidelines:**

**A4310:** Insertion tray without drainage bag and without catheter

**A4312:** Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone

**A4340:** Indwelling catheter, specialty type, (e.g., coude, mushroom, wing, etc.) each

**A4354:** Insertion Tray with drainage bag but without catheter

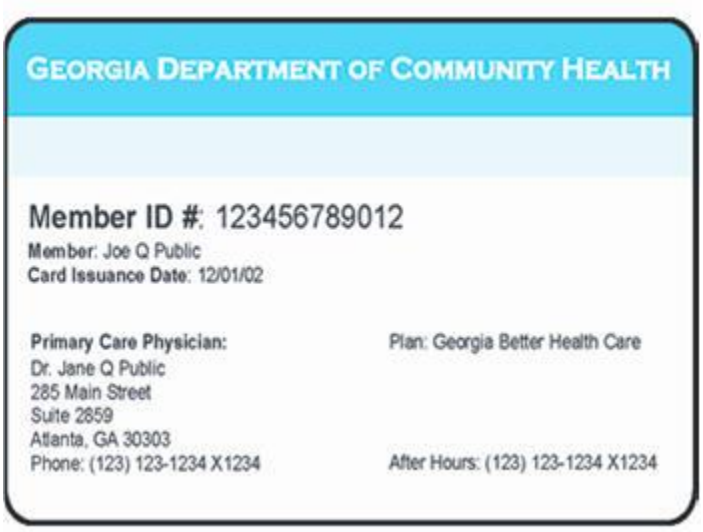
**Limitations:** All codes are limited to two (2) units per month.

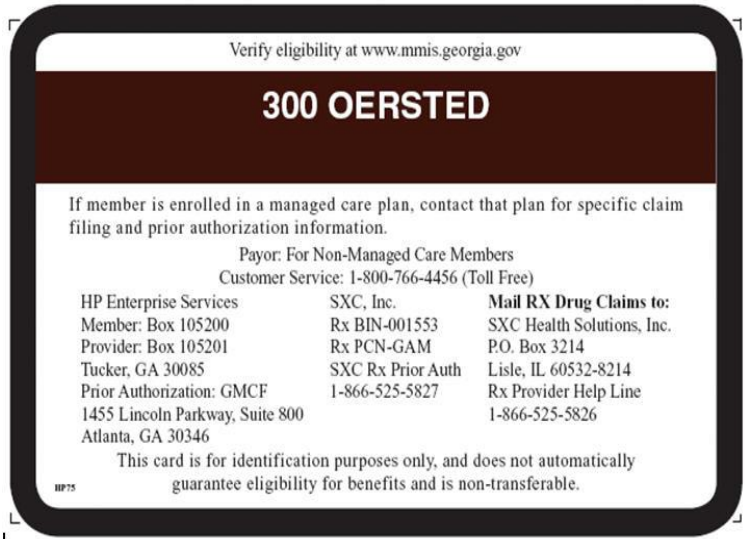
One insertion tray is covered per episode of indwelling catheter insertion up to the GA Medicaid limit. Catheter insertion trays are not medically necessary for clean, nonsterile, intermittent catheterization and are non-covered.

When codes A4340 and A4312 are being used, there must be documentation in the beneficiary's medical record (and DME record) of the medical necessity for that catheter rather than a straight Foley-type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex). In addition, the particular catheter must be necessary for the beneficiary. For example, use of codes A4340 for female beneficiaries is rarely medically necessary. Documentation of medical necessity may be requested and must be kept in the beneficiary's DME file.

# APPENDIX A

## SAMPLE MEDICAID ID CARD



# APPENDIX B

(Rev. 07/22)

## STATEMENT OF PARTICIPATION

**The new Statement of Participation is available in the Provider Enrollment Application Package.**

The Georgia Paperless Initiative was launched on September 1, 2014, between the Georgia Department of Community Health (DCH) and DCH's fiscal agent (partner vendor) Gainwell Technologies (f.k.a. DXC Technology). DCH and Gainwell Technologies teamed up to transition to a paperless system for Medicaid provider enrollment applications, claims filing, appeals and reimbursement.

Effective May 1, 2015: all claims, appeals, forms, prior authorizations (PA), and provider enrollment (PE) documents should be submitted electronically through the GAMMIS web portal at www.mmis.georgia.gov. This includes paper claims, appeals, provider inquiry forms (DMA -520 /520A), PAs, Medicare and Medicare Advantage claims, Institutional claims, Inpatient Part B only claims, and PE applications.

As of May 1, 2015, the following P.O. Boxes are no longer valid and should not be used:

P.O. Box 105201 - Provider Enrollment / EDI Services / CMS 1500 Claims
P.O. Box 105203 - Crossover Claims
P.O. Box 105204 - UB04 Claims
P.O. Box 105205 - ADA 2006 Dental Claims
P.O. Box 105206 - Adjustments and Voids
P.O. Box 105207 - TPL / Finance / Buy-in

Only the following P.O. Boxes remain open and are to be used as instructed by Gainwell Technologies:

P.O. Box 105200 - Member and Provider Correspondence
P.O. Box 105208 - Retroactive Eligibility Claims, Out of State Claims,
P.O. Box 105209 - Miscellaneous Non-claims documents and Business Reply mail

For additional information on the paperless initiative, refer to the Frequently Asked Questions (FAQs) for Providers that was posted March 18, 2015, on the Georgia Department of Community Health's (DCH) website (www.dch.ga.gov) titled "Transition to Paperless Processes". Access to the DCH-i newsletter and the latest FAQs was posted on March 23, 2015, at the following web address http://dch.georgia.gov/publications.

You may also contact Gainwell Technologies at (800) 766-4456 or through the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov for further guidance.

Thank you for your continued participation in the Georgia Medicaid Program.

# APPENDIX C

## INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION REQUEST FORM AND CMS-1500 (version 02/12) CLAIM FORM

This section provides detailed instructions for completing the Prior Authorization Request Form and Detailed instructions for completing the CMS-1500 (version 02/12) claim form. This information is also found in the Billing Manual, Section 5.1.2 pages 30 thru 34. Also see Section 805.1 for specific instructions regarding "serial numbers". The DMA-610 form is found on the web: www.mmis.georgia.gov. A physician certification of medical necessity should always be attached to the completed form, and both should be mailed, faxed, or submitted via the web. Please see the information below for the web address as it is a requirement for all prior authorization requests to be submitted via the web portal effective 12/01/2014.

**Web:** www.mmis.georgia.gov

Requests for DME services is not accepted by phone or fax.

A prior authorization sample form with required fields is listed below:

| Field | Data Component | Instructional Information |
|---|---|---|
| 1 | Member Name | Enter member name exactly as it appears on the ID card (last name first) |
| 2 | Member ID | Enter the member's ID exactly as it appears on the ID card (this number is subject to change and should be verified monthly prior to dispensing equipment or supplies) |
| 3 | Nursing Home | Enter Yes or No (DME and Supplies are typically noncovered for members residing in a nursing home) |
| 4 | Member's Date of Birth | Enter the member's valid date of birth |
| 5 | Member's Sex | Enter the member's sex |
| 6 | Member's Address | Enter the member's address at the time of request |
| 7 | Member's Phone # | Enter the member's phone number at time of request |
| 8 | Prescribing Physician/ Practitioner's Name and Address | Enter the prescribing physician or practitioner's name and address at time of request |
| 9 | Prescribing Physician's Provider Number | Enter the Ordering, Referring, Prescribing provider ID |
| 10 | Prescribing Physician's Phone Number | Enter the prescribing physician's valid phone number |
| 11 | Provider of Service(s) Name and Address | Durable Medical Equipment provider's name and address |

| | | |
|---|---|---|
| 12 | Provider of Service(s) Medicaid Supplier ID | Enter the DME supplier's Medicaid provider ID |
| 13 | Provider of Service(s) Phone number | Enter the DME supplier's phone number |
| 14 | Authorization Period | Enter the begin date for the prior authorization request (Prior approval staff will enter the through date). Note- Capped rentals do not exceed ten (10) months, and Indefinite Rentals do not exceed twelve (12) months. Purchases typically result in an authorization period of one hundred and twenty (120) days to allow sufficient time to receive, construct, and deliver the item(s). |
| 15 | Description of Services Requested | Enter the general description of the service the physician ordered. |
| 16 | Primary Diagnosis | Enter the primary diagnosis supporting the need for the equipment or supplies requested. Secondary diagnoses that provide further evidence of medical necessity are strongly encouraged. |
| 17 | Diagnosis Codes | Enter the diagnosis codes that reflect the greatest level of specificity based on physician documentation. ICD-9-CM codes must be reported on or before 09/30/2015 and ICD-10-CM codes must be reported on or after 10/01/2015. |
| 18 | Justification and Circumstances for Required Services | Provide a detailed rationale for the justification of the equipment, including any special features, length of time the physician order services, and any other information that should be considered. |
| 19 | Description of Equipment or Supplies | Provide a detailed description of the equipment and/or supplies for which the authorization is being requested. Include the manufacturer's name and model number on the request. Use additional forms if necessary, but do not report more than six (6) lines on one (1) form. |
| 20 | HCPCS Level II Codes | DME services are reported by indicating the most accurate HCPCS level II code available for the actual supplies/equipment ordered by the treating physician and provided by the DME supplier.<br><br><u>Modifications</u> - List the purchase procedure code on line one (1) followed by modification procedure code(s) on the following lines. List no more than a total of six (6) procedure codes for any Prior Authorization Request form. If additional forms are necessary to include any remaining procedure code(s), a purchase procedure code with a billed amount of zero dollars is required on the first line of |

| | | |
|---|---|---|
| | | any additional Prior Authorization Request form(s) used.<br><br>Repairs - List the purchase procedure code with a billed amount of zero dollars on line one (1) followed by the repair procedure code(s) on the following lines. This is informational only and should only be provided on the prior authorization, but not billed on the claim. Providers that submit the base code with 0.00-dollar amount on claims will incur denials for same or similar equipment (rev.10/15). If additional prior authorization forms are required, refer to the above paragraph about modifications for specific instructions. |
| 21 | Requested or Estimated Reimbursement Rate | For manually priced items providers should enter the amount requested. The actual approved rate will be based on current policy guidelines as set forth by the Department. DO NOT enter rates for items that are listed on the fee schedule. |
| 22 | Months or Units Requested | Enter the number of units requested, based on the item submitted.<br><br>Example: Purchase is typically one (1) unit<br>Example: Capped Rental Period ten (10) units |
| 23 | Units Per Claim | Enter the units on the claim based on a monthly claim submission or one-time purchase (depending on approval) |
| 24 | Provider's Signature | The provider of services must sigh the prior Authorization request if applicable or must have the A signature on file with the Department. |
| 25 | Date | Enter the date the request for services is made. |
| 26 | Request | DEPARTMENT USE ONLY- The determination or action will be noted in this section upon receipt of the request. If "Approved as Changed" block is checked, please note changes to any of the following areas:<br>Item 14 - Authorization period may be adjusted.<br>Item 20 - Procedure code may be changed<br>Item 21 - Requested amount may be adjusted. |
| 27 | Signature | DEPARTMENT USE ONLY- Department of Medical Assistance Authorized Signature |
| 28 | Date | DEPARTMENT USE ONLY- The date approval was entered. |
| 29 | Explanation | DEPARTMENT USE ONLY- The prior authorization review team will provide comments concerning the request submitted. |

# THE PRIOR AUTHORIZATION REQUEST FORM
## DMA-610 (Rev. 01/18)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE

### PRIOR AUTHORIZATION REQUEST*

**CHECK ONE:**
☐ DME ☐ O&P ☐ CASE MGMT.

MAIL COMPLETED FORMS TO:
**GMCF**
**P. O. Box 105329**
**Atlanta, Ga. 30348**

| 1. Member Name (Last, First, M.I.) | 2. Medicaid ID No.: | 3. Nursing Home: ☐ Yes ☐ No |
|---|---|---|

| 4. Birth Date: | 5. Sex: ☐ Male ☐ Female | 6. Address: | 7. Telephone Number: |
|---|---|---|---|

| 8. Prescribing Physician/Practitioner Name & Address: | | 11. Provider of Service(s) Name & Address: | |
|---|---|---|---|
| 9. Provider License Number: | 10. Telephone (AC / Number): | 12. Medicaid Provider Number: | 13. Telephone (AC / Number): |

| 14. Requested Dates of Service: From: / / Thru: / / | 15. Description of Service(s) Requested | |
|---|---|---|
| | 16. Primary Diagnosis Requiring Service(s) | 17. ICD 9-CM |

18. Justification and Circumstances for Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S)

| | 19. Description of Procedures, Equipment or Other Services | 20. Procedure Code | 21. Requested or Estimated Price Per Unit | 22. Months of Units of Service Requested | 23. Units per Claim |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |

24. Provider's Signature:→ | 25. Date Submitted:

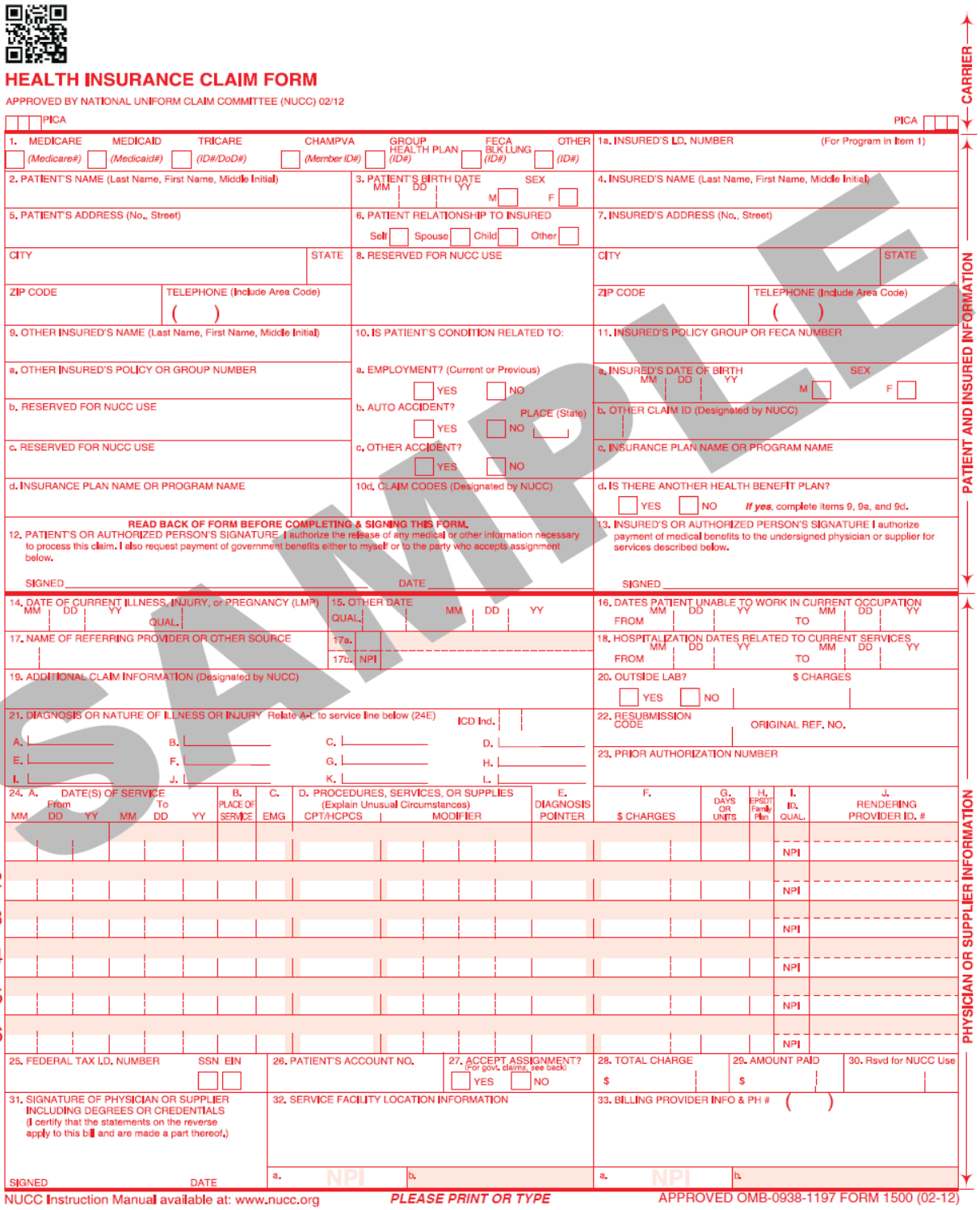
**Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of service.*

*This request is subject to Retrospective Peer Review.*

DMA 610 Rev. (07/10)

## NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions

General Instructions on filling out the 1500 claim form are found in the Billing Manual on the web: [www.ghp.georgia.gov](http://www.ghp.georgia.gov).



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12 (rev. 04/14):

| FLD LOCATION | NEW Change |
|---|---|
| Header | Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code) |
| Header | Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE." |
| Header | Replaced "08/05" with "02/12" |
| Item Number 1 | Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)." |
| Item Number 1 | Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN" |
| Item Number 1 | Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG." |
| Item Number 1 | Changed "(ID)" to "(ID#)" under "OTHER". |
| Item Number 8 | Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**." |
| Item Number 9b | Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**." |
| Item Number 9c | Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**." |
| Item Number 10d | Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.**<br>**FOR DCH/HP:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID. |
| Item Number 11b | Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier |
| Item Number 11d | Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?) |
| Item Number 14 | Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier."<br>**FOR DCH/HP: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**. |
| Item Number 15 | Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care |

| | |
|---|---|
| | Date); 444 (First Visit or Consultation). |
| Item Number 17 | Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising.<br>**FOR DCH/HP:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.** |
| Item Number 19 | Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)."<br>**FOR DCH/HP:** Remove the Health Check logic from field 19 and add it in **field 24H.** |
| Item Number 21 | Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)." |
| Item Number 21 | Removed arrow pointing to 24E (Diagnosis Pointer). |
| Item Number 21 | Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator.<br>Use the highest level of code specificity in FLD Locator 21.<br><br>**Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)** |
| Item Number 21 | Removed the period within the diagnosis code lines |
| Item Number 22 | Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are:<br>7 (Replacement of prior claim)<br>8 (Void/cancel of prior claim) |
| Item Numbers 24A – 24 G (Supplemental Information) | The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F<br>**FOR DCH/HP**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning). |
| Item Number 30 | Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**." |
| Footer | Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)." |

# APPENDIX D

(Rev. 01/22)

## DURABLE MEDICAL EQUIPMENT CODES THAT REQUIRE MANUAL PRICING

(MANUFACTURER'S QUOTE INVOICE REQUIRED)

Appendix D - Contains the list of durable medical equipment services with unique HCPCS codes or Miscellaneous HCPCS codes but are without Medicare based or nationally accepted rates. HCPCS codes in Appendix D require prior approval and must be submitted with the manufacturer's quote invoice that contains the following:

The pricing methodology for manually priced items that contain all required components (a-c) are reimbursed at 40% above the provider's cost (cost should include the primary discount deduction) **up to the Medicaid maximum allowable amount**. The Department does not reimburse MSRP.

a) MSRP
b) Primary Discount (no other discount must be reported)
c) Net cost (total amount after all discounts have been subtracted)
d) Applicable HCPCS Code(s)

All manually priced items require prior approval. Providers that deliver equipment or components of equipment listed as requiring manual pricing (appendix D or E), prior to receiving approval through the prior authorization process are in violation of this policy and may be subject to recoupment during an audit. Providers must submit the approved dollar amount exactly as it is entered in the authorized dollars field by Alliant Health Solutions when submitting claims for reimbursement of manually priced items. It is not appropriate to bill an amount in excess of what has been approved on the prior authorization as this may result in the suspension or denial of claims. Any claim submitted in excess of what is approved that results in an overpayment will be subject to recoupment.

FAILURE TO OBTAIN PRIOR APPROVAL BEFORE RENDERING/DELIVERING THE SERVICE OR COMPONENT WILL RESULT IN CLAIMS DENIALS OR RECOUPMENT OF FUNDS.

---

**NOTE: Items that have multiple components or greater than one unit will have one combined total approved with only one unit allowed. This is based on published pricing methodology for manually priced items.**

| Added/ Revised | HCPCS CODE | MOD | DESCRIPTION | MAX UNITS | PA WITH QUOTE | UNDER 21 YEARS |
|---|---|---|---|---|---|---|
| 04/18 | E0194 | RR | AIR FLUIDIZED BED | 1 | YES | |
| | E0240 | U1 | REHAB AID (TOILET/BATH) ATP/RRTS or CRTS REQUIRED **(DO NOT USE FOR ITEMS LISTED AS NONCOVERED)** | 1 | YES | |
| | E0637 | NU | COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, PEDIATRIC, | 1 | YES | YES |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS (MULTI-POSITIONAL) | | | |
| | E0638 | NU | STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS | 1 | YES | YES |
| | E1009 | NU | WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, MECHANICALLY LINKED LEG ELEVATION SYSTEM, INCLUDING PUSHROD AND LEG REST, EACH | 1 | YES | |
| | E1011 | NU | MODIFICATION TO PEDIATRIC SIZE WHEELCHAIR, WIDTH ADJUSTMENT PACKAGE (**NOT TO BE DISPENSED WITH INITIAL CHAIR**) | 1 | YES | YES |
| | E1017 | NU | HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY-DUTY MANUAL WHEELCHAIR, EACH | 1 | YES | |
| | E1018 | NU | HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY-DUTY POWER WHEELCHAIR, EACH | 1 | YES | |
| | E1090 | NU | HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RES | 1 | YES | |
| | E1130 | NU | STANDARD WHEELCHAIR, FIXED FULL-LENGTH ARMS, FIXED OR SWING AWAY DETACHABLE FOOTRESTS | 1 | YES | |
| | E1140 | NU | WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS | 1 | YES | |
| | E1220 | NU | WHEELCHAIR; SPECIALLY SIZED OR CONSTRUCTED, (INDICATE BRAND NAME, MODEL NUMBER, IF ANY) AND JUSTIFICATION | 1 | YES | |
| | E1231 | NU | WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM | 1 | YES | YES |
| | E1260 | NU | LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST | 1 | YES | |
| | E1290 | NU | HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST | 1 | YES | |
| | E2216 | NU | MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED | 1 | YES | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | PROPULSION TIRE, ANY SIZE, EACH | | | |
| | E2217 | NU | MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH | 1 | YES | |
| | E2218 | NU | MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH | 1 | YES | |
| | E2230 | NU | MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM | 1 | YES | |
| | E2291 | NU | BACK, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE | 1 | YES | YES |
| | E2292 | NU | SEAT, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE | 1 | YES | YES |
| | E2293 | NU | BACK, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE | 1 | YES | YES |
| | E2294 | NU | SEAT, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE | 1 | YES | YES |
| | E2300 | NU | WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE | 1 | YES | |
| | E2301 | NU | WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM, ANY TYPE | 1 | YES | |
| | E2331 | NU | POWER WHEELCHAIR ACCESSORY, ATTENDANT CONTROL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE | 1 | YES | |
| | E2372 | NU | POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH | 1 | YES | |
| 04/14 | E2510 | U1 | MOBILE DEVICE USED AS SPEECH GENERATING DEVICE FOR AAC **REQUIRES 3 YEAR LOSS INSURANCE** | 1 | YES | YES |
| 04/14 | E2511 | U1 | AAC SOFTWARE/APPLICATION FOR USE WITH MOBILE DEVICE USED AS SPEECH GENERATING DEVICE | 1 | YES | YES |
| | E2512 | NU | ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM | 1 | YES | YES |
| | E2599 | NU | ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED | 1 | YES | YES |
| 04/14 | E2599 | U1 | HEAVY DUTY PROTECTIVE CASE FOR MOBILE DEVICE USED AS SPEECH GENERATING DEVICE ONLY | 1 | YES | YES |
| 04/14 | E2599 | U2 | REPLACEMENT CHARGER/ADAPTER | 1 | YES | YES |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | FOR MOBILE DEVICE USED AS SPEECH GENERATING DEVICE ONLY | | | |
| | E2599 | U3 | ACCESSORY FOR SPEECH GENERATING DEVICE, MISCELLANEOUS | 1 | YES | YES |
| | E2609 | NU | CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE | 1 | YES | |
| | E2610 | NU | WHEELCHAIR SEAT CUSHION, POWERED | 1 | YES | |
| | E2617 | NU | CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE | 1 | YES | |
| | E8000 | NU | GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS | 1 | YES | YES |
| | E8001 | NU | GAIT TRAINER, PEDIATRIC SIZE, UPRIGHT SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS | 1 | YES | YES |
| | E8002 | NU | GAIT TRAINER, PEDIATRIC SIZE, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS | 1 | YES | YES |
| | K0739 | U2 | REPAIR, MINOR PARTS, DME NON-OXYGEN **(REQUIRES ITEMIZED LIST WITH QUOTE INVOICE)** | 1 | YES | |
| | K0740 | U2 | REPAIR, MINOR PARTS, OXYGEN RELATED **(REQUIRES ITEMIZED LIST WITH QUOTE INVOICE)** | 1 | YES | |
| | K0830 | NU | POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | 1 | YES | |
| | K0831 | NU | POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | 1 | YES | |
| | K0868 | NU | POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | 1 | YES | |
| | K0869 | NU | POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | 1 | YES | |
| | K0870 | NU | POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | 1 | YES | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | K0871 | NU | POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | 1 | YES | |
| | K0877 | NU | POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | 1 | YES | |
| | K0879 | NU | POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | 1 | YES | |
| | K0880 | NU | POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS | 1 | YES | |
| | K0884 | NU | POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | 1 | YES | |
| | K0885 | NU | POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | 1 | YES | |
| | K0886 | NU | POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | 1 | YES | |
| | K0890 | NU | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS | 1 | YES | YES |
| | K0891 | NU | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS | 1 | YES | YES |

# APPENDIX E

(Rev. 10/15, 07/14, 04/14, 1/19)

## LIST OF COVERED WHEELCHAIR COMPONENTS AND ACCESSORIES NOT OTHERWISE SPECIFIED (K0108) THAT REQUIRE MANUAL PRICING

(MANUFACTURER'S QUOTE INVOICE REQUIRED)

Appendix E - Contains the list of items that are considered reimbursable through the use of HCPCS code K0108 when they are not considered included in the base code and there is no specific HCPCS code for the component. These items are without Medicare based or nationally accepted rates. HCPCS codes in Appendix E require prior approval and must be submitted with the manufacturer's quote invoice that contains the following:

The pricing methodology for manually priced items that contain all required components (a-c) are reimbursed at 40% above the provider's cost (cost should include the primary discount deduction) **up to the Medicaid maximum allowable amount**. The Department does not reimburse MSRP.

a) MSRP
b) Primary Discount (no other discount must be reported)
c) Net cost

All manually priced items listed in this table are reported as K0108 and require prior approval. Providers that deliver equipment or components of equipment listed as requiring manual pricing (appendix D or E), prior to receiving approval through the prior authorization process are in violation of this policy and may be subject to recoupment during an audit. Providers must submit the approved dollar amount exactly as it is entered in the authorized dollars field by Alliant Health Solutions when submitting claims for reimbursement of manually priced items. It is not appropriate to bill an amount in excess of what has been approved on the prior authorization as this may result in the suspension or denial of claims. Any claim submitted in excess of what is approved that results in an overpayment will be subject to recoupment.

FAILURE TO OBTAIN PRIOR APPROVAL BEFORE RENDERING/DELIVERING THE SERVICE OR COMPONENT WILL RESULT IN CLAIMS DENIALS OR RECOUPMENT OF FUNDS.

---

**NOTE: Items that have multiple components or greater than one unit will have one combined total approved with only one unit allowed. This is based on published pricing methodology for manually priced items.**

| HCPCS CODE | DESCRIPTION (DO NOT REPORT OTHER ITEMS OR NON-WHEECLCHAIR RELATED ITEMS WITH HCPCS CODE K0108) |
|---|---|
| K0108 | ABDUCTOR BRACKET, FLIP DOWN |
| K0108 | ABDUCTOR, EXTENDED |
| K0108 | ACTUATOR, STROKE |

| HCPCS CODE | DESCRIPTION<br>(DO NOT REPORT OTHER ITEMS OR NON-WHEECLCHAIR RELATED ITEMS WITH HCPCS CODE K0108) |
|---|---|
| K0108 | ADAPTER, PIN |
| K0108 | ADAPTER VALVE, PRESTA |
| K0108 | ADDUCTOR, FLAT KNEE, EACH |
| K0108 | ARM, SHORT |
| K0108 | ASSAY, MTG. LINK, QUAD |
| K0108 | ASSEMBLY HARDWARE, KNEE PAD, ADDUCTOR |
| K0108 | AXLE PLATE, REAR SUSPENSION |
| K0108 | AXLE, T-NUTS, QUICK RELEASE |
| K0108 | BACK CHANNEL |
| k0108 | BACK TYPE, ADJUSTABLE |
| K0108 | BACKPACK (MEDICALLY NECESSARY) |
| K0108 | BACKPACK, VENTILATOR BAG |
| K0108 | BACKREST, ALUMINUM |
| K0108 | BAG, VENT TRANSPORT |
| K0108 | BAR, SWING AWAY SUBASIS |
| K0108 | BASE, BOOSTER (KID KART) |
| K0108 | BATTERIES, GEL, HEAVY DUTY |
| K0108 | BATTERY TRAY MODIFICATION |
| K0108 | BLACK SPOKES, REAR WHEEL SIZE |
| K0108 | BOOT |
| K0108 | BRACKET, HIP GUIDE |
| K0108 | BRACKET, CENTER MOUNT INTERFACE |
| K0108 | BRACKETS, TRANSPORT CHAIR |
| K0108 | BUSHING TIN, TUBE END |
| K0108 | CABLE, ADAPTER |
| K0108 | CABLE, INTERFACE |
| K0108 | CABLE, POWER SUPPLY |
| K0108 | CANES, CUSTOM BACK |
| K0108 | CAP, HEAT TUBE |
| K0108 | CAP, SCREW FRONT HEAD TUBE |
| K0108 | CARBON FIBER |
| K0108 | CASTER STEM, (INCLUDES HARDWARE) |
| K0108 | CENTER MOUNT, KNEE ANGLE, ADJUSTABLE |
| K0108 | CLAMPS, FRAME |
| K0108 | CLAMPS, SLIDE BELT, POSITIONING |
| K0108 | CLIPS, VERSA LOCK |
| K0108 | COLLAR, HEADMASTER |
| K0108 | COVER, ABDUCTOR |
| K0108 | COVER, ABDUCTOR, FLIP DOWN |

| HCPCS CODE | DESCRIPTION<br>(DO NOT REPORT OTHER ITEMS OR NON-WHEECLCHAIR RELATED ITEMS WITH HCPCS CODE K0108) |
|---|---|
| K0108 | COVER, FOOT PLATE |
| K0108 | CUSHION, SEAT, INCREASED ABDUCTION CONTOUR, CUSTOM |
| K0108 | DISPLAY, MK6 |
| K0108 | DRIVE WHEELS, FLAT FREE INSERTS |
| K0108 | FOAM, SPECIAL (CUSTOM) |
| K0108 | FOOT BOX |
| K0108 | FOOT BOX, SPLIT |
| K0108 | FOOT CONTROL, MOUNTING ADAPTER |
| K0108 | FOOT SUPPORTS, PADDED STRAPS |
| K0108 | FOOTBOARD |
| K0108 | FOOTPLATE PAD, FI; CALF PANEL, CUSTOM ONE-PIECE, LOWER EXTREMITY SUPPORT |
| K0108 | FOOTREST, ALUMINUM PLATFORM (PAIR) |
| K0108 | FOOTRESTS, BUILD UP |
| K0108 | FOOTRESTS, CONTRACTURE, BILATERAL |
| K0108 | FOOTRESTS, HEAVY DUTY DROP IN |
| K0108 | FRAME OPTION, ABDUCTION (FLARED) |
| K0108 | FRAME, GROWING DEPTH, BACK |
| K0108 | FRAME, TRANSIT OPTION |
| K0108 | FRAME, WIDTH |
| K0108 | GEL BLOCKS, ELBOW |
| K0108 | GEL INSERT, CUSTOM POSITIONER, HIP |
| K0108 | GEL PADS, ARMRESTS |
| K0108 | GEL PROTECTOR, FULL LENGTH |
| K0108 | GEL PROTECTOR, PARTIAL (ARM/LEG, ETC.) |
| K0108 | GEL WRAP, FIXED FRAME, MANUAL |
| K0108 | GEL WRAPS, LEGS |
| K0108 | GRIP, FOAM |
| K0108 | GRIPS |
| K0108 | GUARDS, SIDE, ALUMINUM RIGID, SMALL, REMOVABLE |
| K0108 | GUIDE BRACKET, HIP |
| K0108 | HANDLE EXTENSION, STROLLER, BACK POST, REMOVABLE |
| K0108 | HANDLE OPTIONS, EXTENSION, STROLLER, REMOVABLE |
| K0108 | HAND RIMS, PLASTIC COATED |
| K0108 | HAND RIMS, PROJECTION (REPORT E0967) |
| K0108 | HARDWARE, CASTER MOUNTING |
| K0108 | HARDWARE, HARDWARE SEAT |
| K0108 | HARDWARE, TRACK MOUNTING |
| K0108 | HARDWARE, TRAY ATTACHMENT |
| K0108 | HARNESS STRAP GUIDES, CHEST |

| HCPCS CODE | DESCRIPTION<br>(DO NOT REPORT OTHER ITEMS OR NON-WHEECLCHAIR RELATED ITEMS WITH HCPCS CODE K0108) |
|---|---|
| K0108 | HEAD/NECKREST COMBO, LARGE |
| K0108 | Heavy Duty Upgrade, >400 lbs. |
| K0108 | HUGGERS, ANKLE |
| K0108 | JAY WEDGE, BASE |
| K0108 | JOYSTICK CONTROL, MUSHROOM |
| K0108 | JOYSTICK CONTROLLER ASSEMBLY, INTEGRATED |
| K0108 | LATCH HOUSING |
| K0108 | LEG LENGTH DISCREPANCY |
| K0108 | LEVER, ARMREST |
| K0108 | LOCK WASHER |
| K0108 | MODIFICATIONS, SOLID BACK |
| K0108 | MODULE, AUXILIARY, 1&2 – ELECTRONIC ACCESSORIES |
| K0108 | MODULE, G-TRACK |
| | MOLDING SUPPLIES, CASTING |
| K0108 | MOLDING SUPPLIES/PLASTER/CHEMICALS |
| K0108 | MOUNTING BRACKET, HEADREST, DETACHABLE |
| K0108 | OVERLAY, FOAM |
| K0108 | OVERLAY, GEL (FOOT PLATES) |
| K0108 | PAD, ABDUCTOR |
| K0108 | PAD, KNEE ADDUCTOR, HANGER MOUNT |
| K0108 | PAD, RAY |
| K0108 | PADS, BELT |
| K0108 | PADS ONLY, LATERAL HIP |
| K0108 | PADS, FLAT |
| K0108 | PADS, FOOTPLATE |
| K0108 | PANEL, CALF |
| K0108 | PIN, ARMREST |
| K0108 | PLATFORM, CENTER MOUNT, ELEVATING/EXTENDED |
| K0108 | PLUG, PIVOT |
| K0108 | POSITIONER, FOOT/KNEE |
| K0108 | POUCH, SET |
| K0108 | PROTECTOR, PIVOT KNEE |
| K0108 | PUSH HANDLE, ACCESSORIES, ROCK CANOPY |
| K0108 | PUSH HANDLES, BOLT ON BACK REST OPTIONS |
| K0108 | PUSH HANDLES, STANDARD |
| K0108 | PUSH HANDLES, BOLD ON, HEIGHT ADJUSTABLE |
| K0108 | RECEIVER, LEFT INV. |
| K0108 | RECEIVER, RIGHT INV. |
| K0108 | RECLINE BACK, SEMI, VAN SEAT |

| HCPCS CODE | DESCRIPTION<br>(DO NOT REPORT OTHER ITEMS OR NON-WHEECLCHAIR RELATED ITEMS WITH HCPCS CODE K0108) |
|---|---|
| K0108 | RELEASE BAR, BACK, ALUMINUM, TISHAFT |
| K0108 | RIGIDIZER CUSHION |
| K0108 | RIMS, SHORTHAND |
| K0108 | SEAT PAN, STANDARD |
| K0108 | SEAT WIDTH, ADJUSTABLE |
| K0108 | SEAT, EXTRA WIDE |
| K0108 | SHORT ARM, GEL, SMALL |
| K0108 | SIDE GUARDS, PLASTIC |
| K0108 | SIDE GUARDS, PLASTIC REG |
| K0108 | SLING DEPTH |
| K0108 | SOFT SPOT |
| K0108 | SOLID BACK, DROP HOOKS, ADJUSTABLE |
| K0108 | SOLID BACK, KNOB RELEASE HARDWARE |
| K0108 | SPACERS, POLY |
| K0108 | SPINE ALIGN KIT |
| K0108 | STRAP KIT, INCLUDES: ARMRESTS, HANDPADS, AND SWIVEL UNITS |
| K0108 | STRAP RISERS, INCLUDES FASTENERS |
| K0108 | STRAP RISERS, STRAIGHT, ADJUSTABLE |
| K0108 | STRAPS, VELCRO, WHEELCHAIR TRAY |
| K0108 | STROLLER EXTENSION ASSAY |
| K0108 | STRUT TUBE |
| K0108 | SUPPLIES, MOLDING CONTOUR |
| K0108 | SUPPLIES, MOLDED SYSTEM (PLASTER/MOLDING) |
| K0108 | SUPPORT SYSTEM, POSITIONING, HEAD AND NECK |
| K0108 | SWITCH, MICRO, ELEVATING |
| K0108 | SWITCHES (CUSTOM) |
| K0108 | SWITCH-MINI, PUSH BUTTON |
| K0108 | SWIVEL UNIT, ELEVATING, ARMRESTS/HANDPADS |
| K0108 | TENSION STRAP CONTROL, ADJUSTABLE |
| K0108 | T-FOAM, SEAT |
| K0108 | TOGGLE, HEAVY DUTY |
| K0108 | TRANSFER HANDLES |
| K0108 | TRANSIT OPTION |
| K0108 | TRANSIT OPTION (KID KART EXPRESS) |
| K0108 | TRAY HARDWARE, CUSTOM CUT-OUT |
| K0108 | TUBE (INCLUDES CLAMP HARDWARE) |
| K0108 | UPGRADE, TRACK |
| K0108 | UPHOLSTERY, BACK, ADJUSTABLE |
| K0108 | VENTILATOR SYSTEM |

| HCPCS CODE | DESCRIPTION<br>(DO NOT REPORT OTHER ITEMS OR NON-WHEECLCHAIR RELATED ITEMS WITH HCPCS CODE K0108) |
|---|---|
| K0108 | VEST, SAFETY, FULL TORSO |
| K0108 | WEDGES |
| K0108 | WHEEL LOCKS, UNI-LOCK |
| K0108 | WOOD MOUNT |
| K0108 | WRIST STRAP, PADDED |

# APPENDIX F

(Rev. 07/14) (Rev. 07/18) (Rev.10/18)

## CERTIFICATION OF MEDICAL NECESSITY FORMS

The attached certificate of medical necessity (CMN) forms must be reviewed and signed by the ordering physician prior to submission for a prior approval request from the DME provider for all items listed below. All information requested on these forms must be fully completed as the required information assists the reviewer in determining medical necessity for the equipment requested and ensures the expeditious review and processing of requests. ***Providers must submit the appropriate CMN forms for prior authorization, any other CMN forms submitted for the equipment listed below will not be accepted.***

Certificate of Medical Necessity forms may contain an area for a detailed list of equipment which may be completed by a DME provider in collaboration with the Physician and/or Physical or Occupational Therapist. This is the ONLY area that a DME provider is allowed to enter information or provide recommendations. If there are multiple evaluations or recommendations required to complete a CMN form, the physician must have signed off in agreement with the final recommendation.

Certain CMN forms require signatures from the ordering physician, PT/OT, and the DME provider (example: Power Wheelchair CMN). CMNs are not valid without all required signatures. Note: ANY information altered or added after the physician has signed the document is invalid for submission to Georgia Medicaid for Prior Authorization or claims reimbursement.

- Apnea/Bradycardia Monitor (Policy specific age limitations) (Rev. 10/14) (Rev. 07/18) (Rev. 1/19)
- Group 1 Pressure Reducing Support Surface (Rev. 07/18) (Rev. 1/19)
- Continuous Positive Airway Pressure Device (CPAP) (Rev. 07/18) (Rev. 1/19)
- Intermittent Assist Device (BIPAP) (Rev. 07/18) (Rev. 1/19)
- Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 07/18) (Rev. 1/19)
- Enteral Nutrition (*Must be under 21 years of age*) (Rev. 10/14) (Rev. 07/18) (Rev. 1/19)
- Hospital Bed (Rev. 07/18) (Rev. 1/19)
- Insulin Infusion Pump (Attach manufacturer's invoice) (Rev. 07/18) (Rev. 1/19)
- Continuous Glucose Monitor (*Must be under 21 years of age*) (Rev. 07/18) (Rev. 1/19)
- Oxygen Equipment (Rev. 10/14) (Rev. 07/18) (Rev. 1/19)
- Patient Lift (Requires PT/OT Evaluation) (Rev. 07/18) (Rev. 1/19)
- Respiratory Suction Pump (Rev. 07/18) (Rev. 1/19)
- Ventilators (*Rev. 10/14*) (Rev. 07/18) (Rev. 1/19) (4/19)
- Custom Durable Medical Equipment (Requires PT/OT Evaluation) (Rev. 07/18) (Rev.10/18) (Rev. 1/19)
- Manual Wheelchair (Requires PT/OT Evaluation if under 21 years of age) (Rev. 07/18) (Rev. 1/19)
- Power Wheelchair (Requires PT/OT Evaluation) (Rev. 07/18) (Rev.10/18) (Rev. 1/19)
- Scooter (POV) (Requires PT/OT Evaluation) (Rev. 07/18) (Rev. 1/19)

- Speech Generating Device (Requires SLP Evaluation) Speech Generating Devices and Mobile Devices Used as a Speech Generating Device with AAC Application or Software (Rev. 07/18) (Rev.10/18) (Rev. 1/19)
- External Infusion Pump and Supplies (Rev. 07/18) (Rev. 1/19)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

## CERTIFICATION OF MEDICAL NECESSITY FOR APNEA/BRADYCARDIA MONITOR

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

**Apnea/Bradycardia Monitors are only covered for members with the following diagnoses. Check all that apply and submit supporting documentation.**

Note: Report ICD-10 Diagnosis Code_____

☐ APNEA ☐ BRADYCARDIA ☐ REFLUX with apnea ☐ SIDS SIBLING (brother or sister)

Length of time monitor will be needed: _____

Additional medical justification is required for members older than ten (10) months of age or for rentals exceeding four (4) months, and includes documentation supporting the following:

Does member have a tracheostomy: ☐ Yes ☐ No

If the member has a tracheostomy, the following is required:

a) A separate letter from the ordering physician is required to justify medical necessity for continued use of an apnea monitor for members older ten (10) months of age or for use beyond a maximum of four (4) rental months.

b) A copy of an actual monitory strip, readout, or download is required, and must document the episode(s) of apnea or bradycardia that occur within the last three months.

I certify that the apnea/ bradycardia monitor requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature_____ Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR GROUP I PRESSURE REDUCING SUPPORT SURFACE

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

Primary Diagnosis: _____ICD-10 Diagnosis Code:_____

Secondary Diagnoses supporting medical necessity: _____

ICD 10 Diagnosis Code(s) _____Length of Need _____

**Risk Factors for decubitus ulcers include:**

☐ Altered mobility ☐ Bedbound ☐ Poor nutritional status

☐ Incontinence of Bladder or Bowel ☐ Increased pressure over bony prominences ☐ Edema

**Does the member presently have decubitus ulcers or skin irritation?**

☐ Yes ☐ No

**Stage of decubitus, if present:**

☐ I ☐ II ☐ III ☐ IV

I certify that the pressure reducing support surface requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE (CPAP)

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

**A copy of the polysomnography must be attached.**

Primary Diagnosis_____ ICD-10 Diagnosis Code_____

☐ Obstructive sleep -apnea (ICD-10 Diagnosis Code CM G47.33)

Secondary Diagnoses supporting medical necessity:_____

ICD 10 Diagnosis Code(s)_____ Length of Need _____

**Related Signs and Symptoms:**

☐ nocturnal hypoxemia (greater than 5% sleep time is below 85% oxygen saturation or oxygen saturation falls less than 75%)

☐ Cor pulmonale (altered structure and/or impaired function of the right ventricle that results from pulmonary hypertension that is associated with diseases of the lung)

☐ Ventricular arrhythmias ☐ Daytime hyper somnolence (Epworth sleepiness score > 10) ☐ Hypertension

**Polysomnography:**

Length of sleep study _____hours Apnea Index _____ Apnea/Hypopnea Index _____

Is surgery an alternative? ☐ Yes ☐ No Is the member cooperative and motivated? ☐ Yes ☐ No

I certify that the continuous pressure airway (CPAP) device requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____ Date_____/_____/_____

Additionally, the respiratory therapist or certified sleep technologist responsible for instruction and fitting of the mask must sign and date below, and the license or certification number must be listed.

Signature of RT/CST _____ Date _____/_____/_____

Certification or License #_____ Expiration Date _____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR INTERMITTENT ASSIST DEVICE (BIPAP)

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

Primary Diagnosis_____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____

ICD 10 Diagnosis Code(s)_____Length of Need _____

Has the member had a trial with a CPAP device? ☐ Yes ☐ No

**If yes, describe the results of the trial:**

_____

_____

**Describe the member's current condition:**

_____

_____

Will the intermittent assist device provide an alternative to a tracheotomy? ☐ Yes ☐ No

**Complete all the following if BIPAP ST is ordered:**

BIPAP Level _____ IPAP _____ EPAP _____ Respiratory Rate _____

**Complete all the following if BIPAP S is ordered:** IPAP _____ EPAP _____

I certify that the intermittent assist (BIPAP) device requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

Additionally, the respiratory therapist or certified sleep technologist responsible for instruction and fitting of the mask must sign and date below, and the license or certification number must be listed.

Signature of RT/CST _____ Date _____/_____/_____

Certification or License # _____ Expiration Date _____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS UNIT)

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis_____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____ICD 10 Diagnosis Code(s)_____

1) Does the member have acute post-operative pain? ☐ Yes ☐ No

2) List the date of surgery resulting in acute post-operative pain _____/_____/_____

3) Does the member have chronic intractable pain? ☐ Yes ☐ No

4) If yes, describe the location and type of chronic intractable pain:

- Location_____
- Type_____

5) How long has the member had intractable pain? List months _____ 6) Estimated Length of Need _____

Clinical Rational:

_____

_____

_____

7) Is this device being prescribed for any of the following conditions? ☐ Yes ☐ No

(Headache, Visceral Abdominal Pain, Pelvic Pain, Temporomandibular Joint (TMJ) Pain, Chronic Lower Back Pain/ Lumbar Pain/ Lumbago) If yes, list all that apply: _____

_____

I certify that the TENS device requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature_____Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

Revised 1/1/2019 CMN Transcutaneous Electrical Nerve Stimulator (Tens Unit) Page 1 of 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR ENTERAL NUTRITION THERAPY FOR MEMBERS UNDER TWENTY-ONE (21) YEARS OF AGE

☐ Initial Certification (3 months) ☐ First Recertification (6 months) ☐ Yearly Recertification (12 months)

☐ Revised Order Based on Change in Medical Need **(Existing PA #)** _____)

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** _____ | **Members Medicaid Number (Do Not List Mother's ID):** _____ |
| **Patient DOB**____/____/____ **Sex**_____ **HT.**_____**(in) WT.**_____**(lbs.)** | |
| **Suppliers Name:** _____ **Suppliers NPI Number:** _____ | Suppliers Address and Telephone Number: _____ _____ _____ |
| **Physicians Name:** _____ **Physicians NPI Number:** _____ | Physicians Address and Telephone Number: _____ _____ _____ |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis_____ ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity: _____

ICD 10 Diagnosis Code(s)_____ Length of Need _____

**Is functional impairment of the alimentary tract present?** ☐ YES ☐ NO

If yes, explain_____

Height change since last certification: _____Weight change since last certification: _____

Is this formula the only form of nutritional intake for this member? ☐ YES ☐ NO

Is this formula necessary in order to prevent mental retardation? ☐ YES ☐ NO; or in order to sustain life? ☐ YES ☐ NO

**Select Type of Administration:**

☐ Oral ☐ G-Tube ☐ NG-Tube ☐ Jejunostomy Tube If requesting tubes, which kind? _____

How many per month?_____ If >3 per month, why?_____ Who changes tubes? _____

**Formula Information:** Formula Ordered: _____HCPCS Code _____ Total Calories per day:_____

**WIC Information (if applicable):**

WIC allotment* in calories per day:_____ **Difference** between total caloric need and WIC allotment:_____

☐ Check if formula is not covered by WIC; if not covered by WIC, send statement from DFAC's verifying it is not covered.

**Note:** All children who are under age 5 should have a WIC allotment - vouchers are to be used for formula for those children who need it. Medicaid only reimburses the amount **not** covered by WIC. Check with member's county DFCS office for WIC allotment.

I certify that the enteral nutrition therapy requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR HOSPITAL BED

Bed Prescribed: ☐ Manual Bed ☐ Semi-electric Bed ☐ Full-electric Bed

**A separate letter from the ordering physician is required to justify the need for a semi-electric or total electric hospital bed.**

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis_____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____

ICD 10 Diagnosis Code(s)_____Length of Need _____

List specific physical limitations which require a **hospital** bed versus a **home** bed:

_____

Percentage of time member is alone % _____ Percentage of time confined to bed % _____

Member is bound to: ☐ Bed ☐ Wheelchair Is member able to ambulate with assistance? ☐ YES ☐ NO

If yes, type of assistance _____

Is member able to ambulate alone? ☐ YES ☐ NO If yes, justify need_____

Primary In-Home Caregiver _____**(Excludes member or physician)**

Physical condition of caregiver_____

Is caregiver capable of adjusting a manual bed? ☐ YES ☐ NO

If no, explain_____

Describe the positions needed in a hospital bed which are not possible in an ordinary bed:

_____

Have pillows, wedges, frame elevator, etc. been tried? ☐ YES ☐ NO

Describe success of above:_____

Prognosis: _____

Additional comments: _____

Date of prior surgery or CVAs: _____

I certify that the hospital bed requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

Revised 1/1/2019 CMN for Hospital Bed Page 1 of 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY EXTERNAL INFUSION PUMP

*THIS DOCUMENT MAY ONLY BE COMPLETED BY THE ORDERING PHYSICIAN*

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB ____/____/____ Sex ____ HT. ____ (in) WT. ____ (lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

**Primary Diagnosis:** _____ ICD-10 Diagnosis Code(s): _____

| | |
|---|---|
| List all drugs requiring the use of the infusion equipment and supplies: | Drug(s):<br><br>Frequency of fuse: _____ Duration of infusion: _____ |
| Select Route of Administration: | ☐ Intravenous ☐ Subcutaneous ☐ Epidural ☐ Other (specify)_____ |
| Select Method of Administration: | ☐ Continuous (>8 hours) ☐ Intermittent (<8 hours) |
| **Based on the information listed above, please select the infusion pump that most appropriately describes the ordered infusion therapy:** | |
| AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR GREATER | E0779 ☐ (Rental only)<br>This pump should be selected for continuous infusion (greater than 8 hours) for the infusion of a single drug.<br><br>Length of Need: _____ |
| AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR LESS | E0780 ☐ (Purchase only)<br><br>This pump should be selected for intermittent infusion (each infusion less than 8 hours) for the infusion of a single drug.<br><br>Length of Need: _____ |

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Patient Name: _____ DOB: _____

| | |
|---|---|
| AMBULATORY INFUSION PUMP, SINGLE OR MULITPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATION EQUIPMENT, WORN BY MEMBER. | E0781 ☐ (Rental only)<br><br>This pump should be selected for the infusion of a multiple drugs.<br><br>Length of Need: _____ |
| **Please select the appropriate supplies based on the number of drugs and duration of infusion therapy.** | |
| SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK | A4221 ☐ ordered per month _____<br>The number ordered should reflect no more than 4 units per month. |
| INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG | A4222 ☐ ordered per month _____<br>**(Should not exceed two per day)** |

Physician Information:

I certify that the prescribed external infusion pump is reasonable and necessary to administer the associated drug and is appropriate for home infusion. I certify that I performed a face to face evaluation documenting the patient's condition for which the infusion therapy is required within 180 days of this order, and that this information is documented in the patient's medical record. I agree to provide the physician notes and other supporting documentation to the Durable Medical Equipment provider or the member's insurance company upon request.

Date of the Face to Face encounter _____/_____/_____ (must be less than 180 days from the date of this order) to see patient for options to treat their speech related diagnoses as listed above.

Physician Signature: _____ Date _____/_____/_____

| | | | |
|---|---|---|---|
| Physician's Printed Name: | | Fax: | |
| Medicaid Provider ID: | | Misc. | |

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR CONTINUOUS GLUCOSE MONITOR

(Must be less than twenty-one (21) years of age or approved on a case-by-case basis)

| | | | | | |
|---|---|---|---|---|---|
| Certification Type/Date: INITIAL __/__/__ REVISED __/__/__ RECERTIFY __/__/__ | | | | | |
| **Members Name:** | | **Members Medicaid Number (Do Not List Mother's ID):** | | | |
| Patient DOB ____/____/____ Sex_____ HT. _____(in) WT. _____(lbs.) | | | | | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | | Suppliers Address and Telephone Number: | | | |
| **Physicians Name:**<br>**Physicians NPI Number:** | | Physicians Address and Telephone Number: | | | |
| HCPCS Code(s) | ☐ K0553 | ☐ K0554 | ☐ A9276 | ☐ A9277 | ☐ A9278 |
| Place of Service | | | | | |

Primary Diagnosis:

_____ ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:

_____ ICD-10 Diagnosis Code(s)_____

Is the ordering physician an endocrinologist? ☐ Yes ☐ No

Is the member currently taking 3 or more insulin injections per day or using an insulin pump? ☐ Yes ☐ No

**Select ALL conditions that apply to the member:**

☐ Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
☐ Hypoglycemic unawareness ☐ Poor glycemic control despite at least 4 finger sticks per day
☐ Recurring diabetic ketoacidosis (DKA) ☐ Hypoglycemia overnight

What is the estimated length of need for continuous glucose monitoring?

List number of months: _____ Number of Supply Refills Ordered _____ (may not exceed twelve (12) months)

What CGM device is being requested? _____

Is this device a therapeutic continuous glucose monitoring system? ☐ Yes ☐ No
Is the member less than twenty-one (21) years of age? ☐ Yes ☐ No

I certify that the continuous glucose monitor and supplies are medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature_____ Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR OXYGEN EQUIPMENT

Estimated length of time oxygen needed: _____ months

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| **Patient DOB**____/____/____ **Sex**_____ **HT.**_____**(in) WT.**_____**(lbs.)** | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis _____ ICD-10 Diagnosis Code_____

***Must be respiratory or cardiac related***

Secondary Diagnoses supporting medical necessity:

_____ ICD-10 Diagnosis Code(s)_____

Select equipment ordered (do not select more than one stationary or portable system):

**Stationary System:** ☐ Compressed Gas ☐ Liquid Oxygen ☐ Oxygen concentrator

**Portable System:** ☐ Compressed Gas ☐ Liquid oxygen

**Liters per minute ordered:** _____ **Hours per day ordered for use:** _____

Method of delivery (nasal cannula, mask, etc.)

_____

**If portable oxygen prescribed, state purpose:**

_____

**Laboratory results:**

ABG* ($PO_2$ result) _____ ☐ Room Air ☐ Oxygen _____%. Date of test: _____

Oxygen saturation* _____ ☐ Room Air ☐ Oxygen _____%. Date of test: _____

*** Copy of laboratory report must be attached to PA request ***

If test not performed on room air, please explain:

_____

If ABG ($PO_2$) exceeds 60 mmHg or if oxygen saturation exceeds 89% for ages 21 and over, justify need for oxygen with supporting clinical rationale supporting the medical need:

_____

_____

I certify that the oxygen equipment is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

Revised 1/1/2019 CMN for Oxygen Equipment Page 1 of 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR PATIENT LIFT

PT/OT EVALUATION REQUIRED

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

Primary Diagnosis _____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:

_____ ICD-10 Diagnosis Code(s) _____

Has the member's PT/OT evaluation been reviewed by the ordering physician?

☐ Yes ☐ No

Member's specific physical limitations (check appropriate boxes):

☐ Cannot stand or walk ☐ Bedbound ☐ Bed to wheelchair bound

If less than 100 pounds, why can't caregiver weight shift without lift?

_____

Who is the member's primary in-home caregiver? _____

What is the physical condition of the in-home caregiver? _____

Is the patient's caregiver able to use a non-hydraulic lift? ☐ YES ☐ NO

If "no", explain? _____

What is the expected length of need for use of the patient lift? _____Months

What is the member's prognosis?

_____

I certify that the patient lift is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date____/____/____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

Revised 1/1/2019 CMN for Patient Lift Page 1 of 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

## CERTIFICATION OF MEDICAL NECESSITY FOR RESPIRATORY SUCTION PUMP

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis _____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity: _____

ICD-10 Diagnosis Code(s) _____

Estimated length of need? _____Months

The member has difficulty clearing secretions that requires the use of a suction pump due to secondary (select all that apply):

☐ Cancer of the throat or mouth
☐ Dysfunction of the swallowing muscles
☐ Unconsciousness or obtunded state
☐ Tracheostomy

This situation below will be reviewed on a case by case basis and the ordering physician should provide any available documentation that the supports the medical necessity.

☐ Copious oral secretions without the ability to clear mucous (Explain)

_____

_____

_____

I certify that the respiratory suction pump is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

Revised 1/1/2019 CMN for Respiratory Suction Pump Page 1 of 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR VENTILATORS

Estimate length of time needed: _____months

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ RECERTIFY ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| **Patient DOB ____/____/____ Sex _____ HT. _____(in) WT. _____(lbs.)** | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis: _____ICD 10 Diagnosis Code_____

***Must be respiratory or cardiac related***

Secondary Diagnoses supporting medical necessity: _____

ICD-10 Diagnosis Code(s)_____ Length of need _____

Is the ventilator being ordered primarily for the treatment of sleep apnea? ☐ YES ☐ NO

**INITIAL CERTIFICATION:** The initial certification is limited to a maximum of six (6) months and requires all the following:

1) Prescription or letter of medical necessity from the ordering physician
2) Copy of a recent History & Physical from the ordering physician
3) Report from hospital social worker, case manager, or provider home checklist confirming the following facts (a-d):

a) The home environment (such as room dimensions and sufficient electrical outlets) will support the use of the ventilator, as ordered, and any other related or medically necessary equipment.
b) The in-home caregiver(s) are capable of caring for the member and have been trained on use of the equipment.
c) The in-home caregiver(s) are capable of and willing to operate the ventilator and related equipment with an assured level of confidence (resuscitation bag, respiratory suction machine, and supplies if applicable).
d) A list of all equipment necessary for the use of the full volume ventilator in the member's home.

**RECERTIFICATION:** The recertification is limited to a maximum of twelve (12) months and requires all the following (1-2):

1) Prescription or letter of medical necessity from the attending physician documenting compliance of usage of the device, and continued medical need
2) A copy of a recent History & Physical from the ordering physician

I certify that a full volume ventilator is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date____/____/____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

Revised 1/1/2019 CMN for Ventilators Page 1of 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR CUSTOM DURABLE MEDICAL EQUIPMENT

## PT/OT EVALUATION REQUIRED

**(To include, but not limited to: WHEELCHAIRS, BATH CHAIRS, GAIT TRAINERS, STANDING FRAMES, SPECIALTY WALKERS, SIT-TO-STAND SYSTEMS, ECT.)**

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

Primary Diagnosis _____ ICD-10 Diagnosis Code _____

Secondary Diagnoses supporting medical necessity: _____

ICD 10 Diagnosis Code(s) _____ Length of Need_____

**PHYSICAL EXAMINATION:**

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

| | |
|---|---|
| Ambulatory Status | Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail: |
| Ability to Self-Propel | Does the member have the ability to self-propel? ☐ YES ☐ NO<br>If no, does the member have a caregiver willing and able to assist in propelling? YES ☐ NO ☐ |
| Endurance | Describe the member's level of endurance: |
| Neck and Head Control | Describe the member's ability to control their head and neck: |
| Trunk | Provide review of exam of the member's trunk: |

Patient Name: _____DOB: _____

| | |
|---|---|
| Pelvis/Hips | Hips Provide review of exam of the member's pelvis/hips: |
| Upper Extremities: | Provide review of exam of the member's upper extremities: |
| Skin Integrity | Provide review of exam of member's skin integrity: |

Describe the activities of daily living and associated environments in which the complex or custom equipment is required for use:

☐ Home (required for in-home ambulation) Percentage of time required _____

☐ School (member's enrolled in school either in-home or in the community):

Enrolled at _____ Hours per Day_____

☐ Community Use (school, physician visits, etc.) ☐ Other_____

Does the member have complex or custom equipment to this request issued during the following time frame?

a) The last 5 years for members over 21? ☐ YES ☐ NO

b) The last 3-5 years for members under 21? ☐ YES ☐ NO

**EQUIPMENT ORDERED**

Please provide the HCPCS code and the description of the item determined to be the most appropriate for the member in the tables below. Provide a detailed rationale of why this equipment was selected and why any available least costly alternative was not deemed appropriate, where one exists.

| HCPCS | BASE |
|---|---|
| | |
| | |

Describe the specific custom equipment that is most appropriate for this member and provide a detailed rational:

_____

_____

_____

_____

_____

| HCPCS | MODIFICATIONS, OPTIONS, ACCESSORIES |
|---|---|
| | |
| | |
| | |
| | |
| | |

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Patient Name: _____ DOB: _____

| | |
|---|---|
| | |
| **HCPCS CONTINUED:** | **MODIFICATIONS, OPTIONS, ACCESSORIES** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Describe the specific **modifications, options, and accessories** that are most appropriate for this member and provide a detailed rational:

_____

_____

_____

_____

_____

**Ordering Physician**

I certify that the complex or custom durable medical equipment listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature_____ Date_____/_____/_____

**Physical or Occupational Therapist (PT/OT)**

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature _____ Date_____/_____/_____

PT/OT Printed Name _____

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

## CERTIFICATION OF MEDICAL NECESSITY MANUAL WHEELCHAIR
## PT/OT EVALUATION REQUIRED FOR MEMBERS UNDER 21

**PT/OT evaluation requirement excludes members under twenty-one (21) years of age requesting a short-term rental.**

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

Primary Diagnosis:_____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____

ICD-10 Diagnosis Code(s)_____ Length of Need_____

**PHYSICAL EXAMINATION:**

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

| | |
|---|---|
| Ambulatory Status | Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail: |
| Amputation Status | Is the wheelchair necessary due to surgery or amputation? ☐ YES ☐ NO<br>If yes, list the type of surgery and the date it was performed:<br>_____ Date_____<br>Expected prognosis: _____ |

Revised 1/1/2019 CMN for Manual Wheelchair Page 1of 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

**Patient Name:**_____ **DOB:**_____

| | |
|---|---|
| CVA or Injury Status | Is this wheelchair necessary due to a CVA or injury? ☐YES ☐ NO<br>If yes, what was the date of the CVA or injury? _____/_____/_____<br>Area affected by the CVA or injury include: _____<br>Describe the injury if applicable: _____<br>Describe limitations: _____ |
| Prognosis | What is the member's potential for rehabilitation? ☐ GOOD ☐ FAIR ☐ POOR<br>What is the member's prognosis? ☐ GOOD ☐ FAIR ☐ POOR |
| Activities of Daily Living | What are the member's activities of daily living that require the use of a wheelchair? |
| Wheelchair Specs | List the wheelchair specifications that are necessary and the justification for medical necessity (elevating footrests, detachable arms, extra-wide, light-weight, etc.)<br>If and extra-wide wheelchair is prescribed, will the member's home (halls and doorways) accommodate the larger size wheelchair? ☐ YES ☐ NO |

**Ordering Physician**

I certify that the manual wheelchair listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR POWER WHEELCHAIR

PT/OT EVALUATION REQUIRED

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis _____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____

ICD 10 Diagnosis Code(s)_____ Length of Need_____

**PHYSICAL EXAMINATION:**

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

| | |
|---|---|
| Ambulatory Status | Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail: |
| Ability to Self-Propel | Does the member have the ability to self-propel? ☐ YES ☐ NO<br>If no, does the member have a caregiver willing and able to assist in propelling? ☐ YES ☐ NO Explain: |
| Cognitive Ability | Describe the member's cognitive ability: |
| Endurance | Describe the member's level of endurance: |
| Neck and Head Control | Describe the member's ability to control their head and neck: |

Patient Name:_____DOB:_____

| | |
|---|---|
| Trunk | Provide review of exam of the member's trunk: |
| Pelvis/Hips | Hips Provide review of exam of the member's pelvis/hips: |
| Upper Extremities: | Provide review of exam of the member's upper extremities: |
| Lower Extremities: | Provide review of exam of the member's lower extremities: |
| Skin Integrity | Provide review of exam of member's skin integrity: |

Provide a detailed rationale as to why a manual wheelchair with the same options/accessories will not meet the specific needs of the member, and why the power wheelchair is required:

_____

_____

Provide justification for the medical necessity of power tilt or recline if applicable:

_____

_____

Was an environmental assessment performed on the member's home with documented dimensions of rooms, doorways, floor coverings, etc.? ☐ YES ☐ NO

Does the home accommodate the PMD, providing sufficient room to maneuver the device, turn around, and have a flat, level surface that allows the device to be used as safely and effectively? ☐ YES ☐ NO

**Describe the activities of daily living and associated environments in which the wheelchair is required for use:**

☐ Home (required for in-home ambulation) Percentage of time required _____

☐ School (member's enrolled in school either in-home or in the community): Enrolled at_____

Hours per day_____ ☐ Community Use (school, physician visits, etc.) Other Explain_____

**Does the member have a custom manual or power wheelchair issued during the following time frame?**

a) The last 5 years for members over 21? ☐ YES ☐ NO

b) The last 3-5 years for members under 21? ☐ YES ☐ NO

**EQUIPMENT ORDERED**

Please provide the HCPCS code and the description of the item determined to be the most appropriate for the member in the tables below. Provide a detailed rationale of why this equipment was selected and why any available least costly alternative was not deemed appropriate, where one exists.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Patient Name:_____DOB:_____

| HCPCS | BASE |
|---|---|
| | |
| | |

Describe the specific wheelchair **base** that is most appropriate for this member and provide a detailed rational:

_____

_____

_____

| HCPCS | MODIFICATIONS, OPTIONS, ACCESSORIES |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Describe the specific **modifications, options, and accessories** that are most appropriate for this member and provide a detailed rational:

_____

_____

_____

**Ordering Physician**

I certify that the power wheelchair listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Physical or Occupational Therapist (PT/OT)**

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature _____ Date_____/_____/_____

PT/OT Printed Name _____

PT/OT GA License Number _____Expiration Date _____/_____/_____

**Licensed DME Supplier**

The NRRTS Member who completed the assessed this member and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

NRRTS Member Signature _____Date_____/_____/_____

Printed Name of NRRTS Member _____

License/Certification # _____ Expiration Date _____/_____/_____

Attach a copy of license or certification with prior authorization request.

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

## CERTIFICATION OF MEDICAL NECESSITY FOR SCOOTER/POWER OPERATED VEHICLE (POV)

PT/OT EVALUATION REQUIRED

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

Primary Diagnosis _____ ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity: _____

ICD 10 Diagnosis Code(s) _____ Length of Need _____

List the Manufacturer's name _____Model# _____

**Required:** Submit a copy of the quote invoice or manufacturer's price list with prior authorization request.

Will the requested device support at least an additional twenty-five (25) pounds in the even the member gains weight over the lifetime of the device? ☐ Yes ☐ No

What is the member's ambulatory status? ☐ Ambulatory ☐ Non-ambulatory ☐ Non-ambulatory for functional distances

If ambulatory, describe functional limitations in detail _____

_____

_____

_____

_____

_____

Can the member functionally propel a manual wheelchair? ☐ Yes ☐ No

Will the member's home accommodate the scooter requested? ☐ Yes ☐ No

Will the scooter be transportable, so the member can use it as required to complete activities of daily living in the home and in the community? ☐ Yes ☐ No

Is the PT/OT evaluation attached to the request for prior authorization? ☐ Yes ☐ No

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

**Patient Name:**_____**DOB:**_____

**Ordering Physician**

I certify that the custom wheelchair listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

**Physical or Occupational Therapist (PT/OT)**

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature _____ Date_____/_____/_____

PT/OT Printed Name _____

PT/OT GA License Number _____Expiration Date _____/_____/_____

**Licensed DME Supplier**

The NRRTS Member who completed the assessed this member and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

NRRTS Member Signature _____Date_____/_____/_____

Printed Name of NRRTS Member_____

License/Certification # _____Expiration Date _____/_____/_____

Attach a copy of license or certification with prior authorization request.

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR SPEECH GENERATING DEVICES AND MOBILE DEVICES USED AS A SPEECH GENERATING DEVICE WITH AAC THERAPY APPLICATION OR SOFTWARE

*SLP ASSESSEMENT REQUIRED*

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB____/____/____ Sex_____ HT._____(in) WT._____(lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

Primary Diagnosis_____ ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity: _____

ICD-10 Diagnosis Code(s)_____

List the Manufacturer's name _____Model #_____

**Required:** Submit a copy of the quote invoice or manufacturer's price list with prior authorization request.

**Equipment Prescribed** (All items must contain the specific names of the Device/Accessories /Software and must match SLP Evaluation, and be the least costly alternative for this product category):

| DETAILED PRODUCT DESCRITPION | HCPCS CODE |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Based on the Speech Language Pathologists report, this equipment has been demonstrated to be useful and effective in the communication needs of the patient? ☐ YES ☐ NO

Expected prognosis with effective use of the device: _____

_____

_____

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Patient Name:_____DOB:_____

This request is for: ☐ Purchase ☐ Rental

The Length of Need will be for _____ months (99= lifetime of device (minimum 3 years)

**Ordering Physician**

I certify that the prescribed mobile device and application ordered are reasonable and necessary to achieve the functional communication goals stated for the patient in the Speech-Language Pathologist's evaluation and plan of care. My order is based on an evaluation that was performed by a licensed Speech-Language Pathologist and includes the patient's physical, language and communication abilities and needs, and who has experience in the use of this device and software or application for speech therapy services., and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Additionally, I certify that I have reviewed a copy of the Speech-Language Pathologist's completed evaluation for the appropriate mobile device and software or application to be used for Augmentative and Alternative Communication therapy, and I agree with the recommendation for this equipment.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature_____ Date_____/_____/_____

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY EXTERNAL INFUSION PUMP

*THIS DOCUMENT MAY ONLY BE COMPLETED BY THE ORDERING PHYSICIAN*

| | |
|---|---|
| Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____ | |
| **Members Name:** | **Members Medicaid Number (Do Not List Mother's ID):** |
| Patient DOB ____/____/____ Sex ____ HT. ____ (in) WT. ____ (lbs.) | |
| **Suppliers Name:**<br>**Suppliers NPI Number:** | Suppliers Address and Telephone Number: |
| **Physicians Name:**<br>**Physicians NPI Number:** | Physicians Address and Telephone Number: |
| HCPCS Code(s) | |
| Place of Service | |

**Primary Diagnosis:** _____ ICD-10 Diagnosis Code(s): _____

| | |
|---|---|
| List all drugs requiring the use of the infusion equipment and supplies: | Drug(s):<br><br>Frequency of fuse: _____ Duration of infusion: _____ |
| Select Route of Administration: | ☐ Intravenous ☐ Subcutaneous ☐ Epidural ☐ Other (specify)_____ |
| Select Method of Administration: | ☐ Continuous (>8 hours) ☐ Intermittent (<8 hours) |
| **Based on the information listed above, please select the infusion pump that most appropriately describes the ordered infusion therapy:** | |
| AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR GREATER | E0779 ☐ (Rental only)<br>This pump should be selected for continuous infusion (greater than 8 hours) for the infusion of a single drug.<br><br>Length of Need: _____ |
| AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR LESS | E0780 ☐ (Purchase only)<br><br>This pump should be selected for intermittent infusion (each infusion less than 8 hours) for the infusion of a single drug.<br><br>Length of Need: _____ |

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Patient Name: _____ DOB: _____

| | |
|---|---|
| AMBULATORY INFUSION PUMP, SINGLE OR MULITPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATION EQUIPMENT, WORN BY MEMBER. | E0781 ☐ (Rental only)<br><br>This pump should be selected for the infusion of a multiple drugs.<br><br>Length of Need: _____ |
| **Please select the appropriate supplies based on the number of drugs and duration of infusion therapy.** | |
| SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK | A4221 ☐ ordered per month _____<br>The number ordered should reflect no more than 4 units per month. |
| INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG | A4222 ☐ ordered per month _____<br>**(Should not exceed two per day)** |

Physician Information:

I certify that the prescribed external infusion pump is reasonable and necessary to administer the associated drug and is appropriate for home infusion. I certify that I performed a face to face evaluation documenting the patient's condition for which the infusion therapy is required within 180 days of this order, and that this information is documented in the patient's medical record. I agree to provide the physician notes and other supporting documentation to the Durable Medical Equipment provider or the member's insurance company upon request.

Date of the Face to Face encounter _____/_____/_____ (must be less than 180 days from the date of this order) to see patient for options to treat their speech related diagnoses as listed above.

Physician Signature: _____ Date _____/_____/_____

| | | | |
|---|---|---|---|
| Physician's Printed Name: | | Fax: | |
| Medicaid Provider ID: | | Misc. | |

# APPENDIX F.1

## Face-to-Face Documentation Requirements

The requirement for documenting a face-to-face encounter between the ordering physician and the Medicaid member may be satisfied by having one of the following on file:

a) A Certificate of Medical Necessity form, provided by Georgia Medicaid, which has been completed by the physician. These documents were updated to provide the request for data entry relating to the date of the face-to-face encounter during the time of CMN completion as it is often difficult to obtain this information after the equipment has been provided.

b) The form listed on page 2 of this appendix (F.1) is a document created by Georgia Medicaid to aid providers in obtaining proof of the face-to-face encounter when providing equipment that may not require a certificate of medical necessity (CMN).

c) A certificate of medical necessity created by the DME provider or physician that contains sufficient information to determine that the physician had a face-to-face encounter with the member within the six (6) months preceding the written order (for complex equipment, ensure that it documents that the member was seen for the purpose of evaluating the member for the equipment being ordered).

It is important to remember that anything a DME provider attests to while obtaining a prior authorization must be reflected in the member's record, is subject to review for verification, and may result in recoupment if invalid information is discovered. This includes the date entered on the PA request for the face-to-face encounter.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# Durable Medical Equipment/Supplies Face-To-Face (F2F) Encounter Certification

| | |
|---|---|
| **Patient Name:** | **D.O.B.** _____/_____/_____ Month Day Year |
| **Medicaid ID:** | **Height**_____ **Weight**_____ **(If equipment is due to growth)** |

**Face to Face Encounter:** I certify that this patient is under my care and that I (MD, DO, DPM), or a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) had a face-to-face encounter with this patient on:

Date of Encounter:_____/_____/_____
Month Day Year

**(The encounter must occur within six months prior to the order for equipment and/or supplies)**

The encounter with this patient was, in whole or in part, for the following medical condition, which is the primary reason the durable medical equipment and/or supplies is necessary:

List the primary medical condition that supports the medical necessity:

_____

_____

I certify, that based on my findings, the following services are medically necessary:

List all items for which an order will be provided to a supplier of durable medical equipment:

Equipment_____

Supplies_____

Attending Physician Name:_____

Address: _____ Phone:_____

NPI _____Signature/Date:_____

**or**

Complete the information below if the clinical professional is anyone other than the attending physician (PA, NP, or CNS):

Name/Credentials: _____

Address: _____ Phone: _____

NPI_____Signature/Date:_____

Supervising Physician Name/NPI: _____

****Please complete this form and submit it to the Durable Medical Equipment provider****

# APPENDIX G

(Eff. 10/13, Rev. 01/14, Rev. 01/16)

## DOCUMENTATION REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT

This appendix provides DME providers with the minimum standards allowed to satisfy documentation requirements in most cases. Providers should review these guidelines prior to submitting requests for prior authorization or claims for the reimbursement of services rendered.

A claim submitted for reimbursement by the Department, where a prior authorization is not required, is considered to be an attestation that:

- All policy guidelines have been met, and
- All required documentation is on file and available upon request.

**Table of Contents:**


1. General Information about Georgia Medicaid Coverage for DMEPOS.
2. Definition of Physician as it relates to DMEPOS
3. Prescription (Order) Requirements
4. Detailed Written Orders (CMN)
5. Written Order Prior to Delivery (Claims Submission) Rev. 01/16
6. Supply Replacement/Utilization
7. Documentation in the Patient's Medical Record
8. Continued Need/ Continued Use
9. Signature Requirements
10. Refills of Items Provided on a Recurring Basis
11. Beneficiary Authorization
12. Proof of Delivery (POD)
13. Advance Beneficiary Notice (ABN)
14. Invoices (Invoice/Manually Priced Items)
15. Face-to-Face Requirement
16. Miscellaneous Documentation Issues
17. NCCI Billing Guidelines


### 1. General Information about Georgia Medicaid Coverage for DMEPOS

For an item to be covered by Georgia Medicaid, it must:

1) Be eligible for a defined Medicaid benefit category;
2) Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
3) Meet all other applicable Medicaid statutory and regulatory requirements.

Before submitting a claim to Georgia Medicaid, the following must be on file: an approved prior authorization (if applicable), a detailed written order, a Certificate of Medical Necessity (CMN) (if applicable), which includes HCPCS codes, face-to-face examination documentation (if applicable), information from the treating physician concerning the patient's diagnosis and prognosis (as it pertains to length of need), and

any information required for the use of specific modifiers or attestation statements as defined in specific medical policies (e.g., PMD). All pertinent documentation from the patient's medical record (e.g., physician, nursing home, or hospice) as needed to establish medical necessity should be obtained. If the information in the beneficiary's medical record does not support medical necessity for the item billed, additional documentation will be requested.

Appropriate Diagnosis Codes: ICD10 Diagnosis Codes; Procedure Codes: CPT or HCPCS Level II codes are required on all claims. Claims billed without both appropriate diagnosis and procedure codes cannot be reviewed or processed and will be denied.

*All documentation listed as a requirement for submitting claims to Georgia Medicaid is an integral part of the medical record and must be maintained in the files for seven years and be available to Georgia Medicaid upon request, including prior authorizations.

## 2. The Definition of a Physician as it Relates to DME

Physician means any of the following entities legally authorized to practice by the State where the function is performed. The services performed by a physician within these definitions are subject to any limitations posed by the State on the specific scope of practice.

- Doctor of medicine
- Doctor of osteopathy (including osteopathic practitioner), must be licensed to practice
- Medicine and surgery
- Doctor of dental surgery or dental medicine
- Doctor of podiatry (see below) or surgical chiropody
- Doctor of optometry

The following practitioners may document the medical necessity of durable medical equipment, and supplies (DME), including completing orders and Certificates of Medical Necessity (CMNs), in place of a physician if the Medicaid policy permits, the services performed are within the scope of practice as defined by the state, and the practitioner is treating the beneficiary for the condition for which the item is needed.

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist

Medicaid coverage for all DMEPOS items furnished or ordered by chiropractors (which is not a covered specialty for DMEPOS) is statutorily excluded; therefore, all DME items ordered by chiropractors will be denied.

Medicaid coverage for all items and services furnished by or ordered by podiatrists is limited by state statutes governing the scope of practice for podiatry. Claims submitted to Georgia Medicaid, when furnished by or ordered by podiatrists practicing outside the

limits of their licensure, will be denied as non-covered. Podiatrists are excluded by statute from ordering a Power Operated Vehicle (POV), or power wheelchair.

### 3. Prescription (Order) Requirements

All orders for durable medical equipment and supplies should contain the following criteria to be considered for coverage:

- The member's name
- The ordering physician's name
- Date of the order (and start date if different)
- Supporting diagnosis
- Description of item(s) ordered
- Length of need
- Quantity ordered (units of each item and number of refills or supply months)
- Physician's signature and date of signature (handwritten or electronic)

### 4. Detailed Written Orders

Detailed written orders (DWO) are required for most transactions involving DME services. Individuals other than the physician may complete the detailed description of the item (except when specified by policy); however, the treating physician must review the detailed description and must personally sign and date the order to indicate agreement with the medical order, and to establish medical necessity. A detailed written order may be in the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document. The DWO must contain the following criteria:

- The member's name
- The member's height and weight (if under 21 or applicable, per policy)
- The diagnoses supporting medical necessity
- The length of need
- The quantity of item(s) ordered
- A detailed description of all items ordered
- HCPCS code(s) for all items ordered
- Date of the order (and start date if different)
- The physician's signature and date
- The physician's NPI

For items provided on a periodic basis, including but not limited to supplies, enteral/parenteral nutrition, etc., the detailed written order must also include:

- The item or supply to be dispensed
- The number of calories per day (if enteral/parenteral supplies)
- The frequency of use (if applicable)
- The route of administration (if applicable)
- The quantity to be dispensed (typically monthly)
- The number of refills (approved months/units, if applicable)

The date of the order is the date entered by the physician unless a different start date is specifically listed. The frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement will be limited to the approved (PA required) or order (no PA required) utilization amount.

The detailed description in the written order must contain a narrative description, brand name or model number when required, and an invoice when required by policy. Regardless of the form of the description, there must be sufficient detail to identify the item requested in the order to determine that the item dispensed was properly coded. The DWO, PA, and any other documentation used in the billing, coding, and reimbursement of the item billed must be maintained for seven years. This documentation is an integral part of the medical record and may be requested either retrospectively or prospectively by Georgia Medicaid, Audit Contractors, or Alliant Health Solutions during the prior authorization or auditing process. The claim shall be denied if a faxed, photocopied, electronic, or signed detailed written order by the treating physician is not on file when prior to submitting a claim to Georgia Medicaid, regardless of if the item requires prior approval (i.e., if there is no order or only a verbal order).

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

For items that require a Certificate of Medical Necessity (CMN), the CMN can serve as the written order, but only if the narrative is sufficiently detailed.

### 5. Written Order Prior To Delivery (Claims Submission)

Durable medical equipment that does not require a prior authorization or is not ordered verbally during a hospital discharge requires a written order be on file at the time the item is dispensed or delivered. All DMEPOS items require a detailed written order prior to submitting a claim to Georgia Medicaid for reimbursement. For these items, a written order must have been both signed and dated by the treating physician and meet the requirements for orders before dispensing the item.

**Guidelines Regarding When New Prescriptions and Detailed Written Order Are Needed:**

- Change in supplier,
- Change in the item, frequency of use, or amount prescribed,
- Change in the length of need, or a previously established length of need expires, or
- State law requires a prescription renewal (e.g., Oxygen and other policy specific equipment requires a PA renewal annually with documentation from the physician indicating the equipment is still medically necessary).

A new order is required when an item is being replaced because the item is worn and has exceeded the reasonable useful lifetime, or the patient's condition has changed. Records must include beneficiary-specific information regarding the need for the

replacement item. This information must be maintained in the files and be available to the Georgia Medicaid, Alliant Health Solutions, or Audit Contractors upon request. Failure to provide the appropriate documentation or providing documentation that contains broad, nonspecific explanations will result in denial of the claim.

**Nurse Practitioner or Clinical Nurse Specialist Rules Regarding Orders and CMNs:**

A nurse practitioner or clinical nurse specialist may give the dispensing order, and sign and date the detailed written order, in the following situations:

- They are treating the member for the condition for which the item is needed,
- They are practicing independently of a physician,
- They bill Medicaid for other covered services using their own provider ID, and
- They are permitted to do all the above in the state where the services are rendered (all licensing, certifications, and credentials required by the state must be both current and valid).

A nurse practitioner or clinical nurse specialist may complete a CMN only if all of the aforementioned criteria are met for signing orders.

**Physician Assistant Rules Concerning Orders and CMNs:**

Physician Assistants may provide the dispensing order and write, sign, and date the detailed written order if all of the following requirements are satisfied:

- The definition of Physician Assistant found in §1861(aa)(5)(A) of the Act is met,
- They are treating the member for the condition for which the item is required,
- They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy,
- They have their own NPI number, and
- They are permitted to perform these services in accordance with state law.

Physician assistants may complete a CMN only if they meet all the criteria described above for signing orders (only handwritten or electronic orders are acceptable, stamped signatures and dates are not acceptable).

**6. Supply Replacement/Utilization – Evidence of Medical Necessity**

If replacement supplies are medically necessary for the use of purchased DME or separately, where permitted, the treating physician must specify on the prescription, or on the CMN (if required), the type of supplies needed and the frequency with which they must be replaced, used, or consumed, and the expected length of need. Supplies may require a new order every six (6) months, but some may allow up to twelve (12) months before a new order or CMN is required. This information is policy specific.

The length of need and utilization for the specific member must be submitted with requests to extend or renew prior authorizations for supplies. Supply utilization information is used as part of the medical necessity determination, therefore ”PRN” or as needed requests or estimates are not acceptable.

Suppliers must submit updated clinical documentation (written orders, current face-to-face encounter documentation, or a revised CMN) and obtain prior authorization if the member's condition changes and results in any type of revision to the original order. Claims submitted with unexpected increases in supply utilization without obtaining the appropriate prior authorization will either result in claims denial or exhaustion of prior authorized units prior to the end of the authorization.

**Acceptability of Faxed/Electronic Orders, Detailed Written orders\CMNs**

When reviewing claims and orders for post or prepayment review of DMEPOS items, Georgia Medicaid, Alliant Health Solutions, and Audit Contractors may encounter faxed, copied, or electronic orders as a standard form of documentation. Electronic orders, Detailed Written Orders/CMNs investigation

## 7. Documentation in the Patient's Medical Record

For any DMEPOS item to be covered by Georgia Medicaid, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered, and for the frequency of use or replacement (if applicable). The information must include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items.

If the information in the patient's medical record does not adequately support the medical necessity for the item, the provider is liable for the dollar amount involved, unless a properly executed ABN of possible denial has been obtained (only permitted for items or services that are non-covered by Georgia Medicaid, elective upgrades, or situations where the same or similar equipment is on file, or where the reasonable useful lifetime has not been reached).

Obtaining ABNs as a standard practice for Medicaid patients is strictly prohibited. If an item requires a CMN or Prior Authorization, a copy of the completed CMN or Approved Prior Authorization must be kept in the patient's record. Orders by a physician alone do not provide sufficient documentation of medical necessity, regardless of if the order is signed by the treating physician or supplier. Information in the patient's medical record must support the medical necessity for the item and substantiate the CMN (if applicable), PA (if applicable), or information on a supplier-prepared statement or physician attestation (if applicable).

The patient's medical record is not limited to the physician's office records. A patient's medical record may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists. Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient for the purpose of determining that an item is reasonable and

necessary without the previously stated supplemental information. For this reason, an attestation statement may be required.

The documentation in the patient's medical record may be requested at any time by Georgia Medicaid, Alliant Health Solutions, or Audit Contractors for prepay and post-pay reviews on a case-by-case basis. If the requestor does not immediately receive the information when requested, or if the information in the patient's medical record does not adequately support the medical necessity for the item, the provider is liable for assigned claims for the dollar amount involved, unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

All documentation used in the determination of coverage or reimbursement of a claim by Georgia Medicaid, Alliant Health Solutions, or Audit Contractors must be maintained in the medical record for five years, with no exception. This includes, but is not limited to:

- Dispensing Orders,
- Detailed Written Orders,
- CMNs (all initial and recertification etc.),
- Georgia Medicaid Prior Authorization (PA number),
- Medical record documentation from the continuum of care (hospital, SNF, HHA, Hospice, etc.)
- All policy specific criteria (e.g., sleep study, oxygen sat, power wheelchair assessments),
- PT/OT Evaluations (It is strictly against policy for a DME provider to complete or alter any clinical portion of this evaluation, there are NO exceptions)
- Therapy Evaluations
- Invoices (for items that require invoice pricing) and
- Delivery Tickets (signed and dated by the patient or representative of the patient [with relationship clearly stated if signed and dated by anyone other than the patient]).

Failure to maintain all documentation listed above and all additional documentation required per Georgia Medicaid Policies for Durable Medical Equipment and Orthotic and Prosthetic policies, for a minimum of five years, may result in the inability to support the medical necessity of the item in question.

## 8. Continued Medical Need

For all DMEPOS items, the initial justification for medical need is established at the time the item is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created at the time of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period as indicated by the length of need submitted for PA approval or listed on the order if no PA is required. Entries in the beneficiary's medical record must have been created prior to the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and DME rentals, in addition to information described above that justifies the initial provision of the item or supplies, information in the beneficiary's medical record must support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the date of service under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills,
- A recent change in the prescription/order
- A properly completed certificate of medical necessity (CMN) or detailed written order (DWO) with the appropriate length of need specified, and
- Timely documentation (face-to-face encounter) in the member's medical record showing usage of the item.

Timely documentation is defined as a record in the preceding six (6) months, unless otherwise specified, per policy.

**Continued Use**

Continued use is the ongoing utilization of supplies or a rental item by a member.
The DMEPOS provider is responsible for monitoring utilization of DMEPOS rental items and supplies. Monitoring of purchased items or capped rental items that have converted to a purchase is not required. Providers must immediately discontinue billing Medicaid when rental items or ongoing supply items are no longer being used by the beneficiary, or when the Prior Authorization or Order for the item expires.

Beneficiary medical records or provider records may be used to confirm that a DMEPOS item continues to be used by the member. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the member's medical record showing usage of the item, related options or accessories, and supplies.
- Requests for refills or replacement supplies in compliance with the refill documentation requirements is sufficient to document the continued use for the base item as well as the refill or replacement.
- Supplier records documenting member confirmation of continued use of a rental item and/or supplies.
- Recertification documentation as required for continued use and reimbursement (e.g., annual recertification, prior authorizations for oxygen).
- Signed and dated delivery tickets for accessories or supplies used separately or in conjunction with member owned base equipment (e.g., CPAP and supplies).

Timely documentation is a record in the preceding six months unless otherwise specified in policy.

## 9. Signature Requirements

For medical review purposes, Georgia Medicaid requires that services provided or ordered are authenticated by the author with ink or electronic date and signature. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

**Exception 1**: Fax of original written or electronic signatures are acceptable for the certifications.

**Exception 2:** CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a Georgia Medicaid of inability to sign the signature due to disability. By affixing the rubber stamp, the provider is certifying that the provider has reviewed the document.

## 10. Refills of Items Provided on a Recurring Basis

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills for consumable supplies, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. This allowance does not change the utilization or maximum unit requirements or limitations; it simply allows a grace period in the delivery time of the supplies.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary

A quantity of supplies exceeding a beneficiary's expected utilization must not be dispensed. Utilization should be monitored to detect changed or atypical utilization patterns. The ordering physician must verify that any changed or atypical utilization is warranted. Updated physician orders must be obtained to accommodate the updated utilization (e.g., obtain a new PA with revised maximum allowed units based on the updated order).

### Refill Documentation

A new prescription/order is needed when:

- Change in supplier,
- Change in the item, frequency of use, or amount prescribed,

- Change in the length of need, or a previously established length of need expires, or
- State law requires a prescription renewal

For items the beneficiary obtains in person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill or proof of delivery.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation or contact between you and the beneficiary. The refill request must occur and be documented prior to shipment. Retrospective attestation statements will be denied.

The refill record must include:

- Member's name or authorized representative (documentation must state relationship of the authorized representative) if anyone other than the member.
- A detailed description of each item that is requested
- For consumable supplies (e.g., supplies that are used such as ostomy or urological supplies and disposed of prior to replacing) the supplier must assess the quantity of each item the member has remaining, to document that the amount remaining is near exhaustion.
- For non-consumable supplies (e.g., supplies of more durable items that are not used up or exhausted, but may need periodic replacing (e.g., CPAP masks and supplies) the supplier must assess to determine if the supplies remain functional, providing replacements or refills only when the supply or item is no longer able to function properly. The functional condition of the item being refilled is expected, in normal situations, to last the billing period as indicated on the SMAP.

This information must be kept on file and available upon request for no less than six (6) years.

## 11. Beneficiary Authorization

For all claims submitted, payment shall be made to physicians and suppliers even without a beneficiary-signed Assignment of Benefits (AOB) Form since the service can only be paid on an assignment related basis for enrolled providers. This includes any mandatory assignment situations and participating physician or supplier situations. When assignment of Medicaid benefits is accepted, you automatically also accept Medicaid's determination of the approved amount as the full and complete fee for the service rendered.

However, the provider must have on file and make available the member or caregiver signed proof of delivery. If the provider does not have sufficient proof of delivery the submit is not reimbursable by the Department and will be subject to recoupment upon review. (Rev. 04/15)

## 12. Proof of Delivery (POD)

### Supplier Proof of Delivery Documentation Requirements

Proof of delivery documentation must be kept for a minimum of five years for all DMEPOS items reimbursed by Georgia Medicaid. Proof of Delivery (POD) is required to verify that the beneficiary received the DMEPOS item(s) and that the item delivered was the actual item reimbursed by Georgia Medicaid, for medical review purposes, and to assist in determining correct coding and billing information for claims submitted for Medicaid reimbursement. Georgia Medicaid must be able to determine from delivery documentation that you have properly coded the item(s) that the item delivered are the same item(s) submitted for Medicaid reimbursement, and that the item(s) are intended for, and received by, a specific Medicaid beneficiary.

Proof of delivery documentation must be available to the Georgia Medicaid, Alliant Health Solutions, and to Contract Auditors upon request. All services that do not have appropriate POD shall be denied and overpayments will be requested. If documentation to support services provided is not available upon request, you may be referred to the OIG/PI for investigation or imposition of sanctions.

### Proof of Delivery and Delivery Methods

A designee is a person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary. The representative of the beneficiary must clearly list the representative's relationship to the patient on all documentation the representative signs.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item, are prohibited from signing or from accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary must be noted on the delivery slip (e.g., spouse, neighbor). The signature of the designee must be legible and dated. If the signature of the designee is not legible, the name of the designee must be noted on the delivery slip. For consumable supplies shipped to beneficiaries on a recurring basis, the tracking number is sufficient for proof of delivery as long as the patient is identified, the address corresponds to the beneficiary, and the items supplied are identified.

Methods of permissible delivery:

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service **(**tracking # required**).**
3. Delivery of items to a nursing facility on behalf of the beneficiary.

### Method 1: <u>Direct Delivery to the Beneficiary</u>

With the Beneficiary's prior approval, you may deliver directly to the beneficiary or to the designee. Here, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

- Member's name

- Delivery address
- Sufficiently detailed description with HCPCS codes that identify the item(s) delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Signature of member or caregiver (if anyone other than member, must contain relationship to the beneficiary)
- Effective July 2014: The technician or representative of the DME supplier that delivers the equipment or supplies must sign and date the delivery ticket. (Example: DME Technician _____Date_____)

The date of signature on the delivery ticket must be the date that the DME or supplies was received by the member or designee. When DME or supplies are delivered directly to the member, the signature date is the earliest date for which a claim for reimbursement may be submitted.

**Method 2: <u>Delivery via Shipping or Delivery Service Directly to a Beneficiary</u>**

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery
service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Member’s name
- Delivery address
- Delivery service’s package identification number (tracking), supplier invoice number or alternative method that links the supplier’s delivery documents or purchase order to the delivery service’s records.
- Sufficiently detailed description with HCPCS codes that identify the item(s) being delivered)
- (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date shipped
- Date Delivered
- Evidence of delivery (keep tracking record in medical file)

If a supplier utilizes a shipping service or mail order, suppliers may use the shipping date as the date of service on the claim with the exception of recurring consumable supplies which have a specified grace period of 10 days (the billing date in this situation is typically the same day of each month). Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above. (Rev. 01/14)

**Method 3: <u>Delivery to Nursing Facility on Behalf of a Beneficiary</u>**

If the items are directly delivered to a nursing facility, the documentation described for Method 1 (see above) is required.

If a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

Regardless of the method of delivery, for beneficiaries who are residents of a nursing facility, information from the nursing facility showing that the item delivered for the beneficiary's use was actually provided to and used by the beneficiary must be in the medical record and be available upon request.

**Exceptions:**

Exceptions regarding dates of service on the claim occur when items are provided in anticipation of discharge from a hospital or nursing facility. DMEPOS items may be delivered to a beneficiary in a hospital or nursing facility for the purpose of fitting or training the beneficiary to properly use of the item. This may be done up to two days prior to the beneficiary's anticipated discharge to home. The date of service on the claim should be the date of discharge and use the Place of Service (POS) as 12 (home). The item must be for subsequent use in the beneficiary's home and community. No billing may be made for the item on those days the beneficiary was receiving training or fitting in the hospital or nursing facility.

**Example**:

A beneficiary is admitted to a hospital stay on May 1. The beneficiary will require the use of a CPAP upon discharge and must be trained on its use while in the hospital. The CPAP is provided to the beneficiary in the hospital on May 5. The beneficiary is discharged from the hospital on May 6. May 6$^{th}$ would be the date of service used for claim submission.

Drugs or other DMEPOS items used by the beneficiary prior to the beneficiary's discharge from the hospital or nursing facility must not be billed. Billing Georgia Medicaid for surgical dressings, urological supplies, ostomy supplies or any other supplies that are provided in the hospital or during a nursing facility stay is not allowed. These items are payable to the facility through the inpatient payment and unbundling or double billing for inpatient and outpatient reimbursement is prohibited, even if the beneficiary wears the item home from the hospital or nursing facility. Any attempt to substitute an item that is payable to you for an item that, under statute, should be provided by the facility, may be considered to be fraudulent. This applies to DMEPOS items delivered to a beneficiary in hospitals, skilled nursing facilities (Place of Service: 31), or nursing facilities (Place of Service: 32, with the exception of items delivered up to two days before discharge for specific use in the home (e.g., walker, wheelchair).

DMEPOS items may be delivered to a beneficiary's home in anticipation of a discharge from a hospital or nursing facility. Arrangement of delivery of the item approximately two days prior to the beneficiary's anticipated discharge to their home is acceptable. The date of service on the claim should be billed as the date of discharge and use the Place of Service (POS) as 12 (home).

## 13. Advance Beneficiary Notice (ABN)

An Advance Beneficiary Notice (ABN) is a written notice that a supplier may give to a Medicaid beneficiary in very limited situations prior to providing items or services that Medicaid does not cover. For example, a provider bills for a same or similar DMEPOS item that Georgia Medicaid has already reimbursed during the reasonable useful lifetime of the equipment, or a convenience item, or items that do not meet the definition of DME. Here, the DME provider would require the patient to sign an ABN because the patient is requesting an item and fully understands the item will be denied by the Georgia Medicaid. The ABN allows the beneficiary to make an informed decision regarding if to receive the items or services for which the beneficiary may have to pay for through out of pocket or through other insurance. An ABN should be issued prior to dispensing an item or service expected to be denied for the following reasons:

- Same or similar equipment
- Convenience items
- Upgrades that are not medically necessary
- Items that are not covered by Georgia Medicaid
- Items that do not meet the definition of DMEPOS items, or
- Items that are expected to deny because they are considered “Not Medically Necessary”

**Example of a Convenience Item or Not Medically Necessary Item:**

The patient requests a CPAP with a heated humidifier. Based on the diagnosis and Georgia Medicaid Policy, the patient does not qualify for a heated humidifier. The patient has stated that a heated humidifier was wanted and was requested regardless of the fact that Medicaid will likely deny coverage. The provider should issue an ABN, and the patient will be liable for the price of the heated humidifier as listed on the denied EOB.

If a properly executed ABN has not been issued, the provider will be liable for the item and service and may not bill for or collect from the patient or must refund amounts collected from the beneficiary.

The ABN must include the following:

- Clearly identify the particular item or service,
- State that the provider assumes that Georgia Medicaid is reasonably likely to deny payment for the particular item or service,
- State and explain reasons for the assumption that Georgia Medicaid is reasonably likely to deny payment for the item or service,
- Clearly state the out-of-pocket cost of the non-covered item or service (may not exceed fee schedule rates where one exists), and

- The beneficiary or designee (relationship to the member must be stated) must sign and date the ABN.

Use of ABNs is expected to be very rare among the Medicaid community. If ABNs are being incorporated into the standard documentation process or are being used as a "blanket" to collect money from beneficiaries for denied claims, the provider will be referred to Program Integrity for a full review. Georgia Medicaid prohibits use of ABNs as a standard documentation process and also the use of ABNs as a blanket to collect money from beneficiaries for denied claims, or similar situations. (Rev. 10/14) Items that were not denied by Medicaid and resulted in payment (primary or secondary) by the Department is considered payment in full if the fee schedule rate has been met. (Rev. 04/15)

## 14. Quote Invoices for Manually Priced Items

For items that must be manually priced by Alliant Health Solutions, submit the actual quote with the **manufacturer's MSRP, the primary discount, and the resulting cost** (secondary and tertiary discounts are not required as they are considered proprietary business information). Do not alter this documentation by adding or removing required pricing or information (e.g., adding in usual or customary charges), or it will be denied. Altering or self-generating invoices will result in denial of prior authorizations and will be investigated. The provider may add an additional document with any information that needs to be reviewed by Alliant Health Solutions. DCH is aware that manufacturers add codes to products that do not meet the description of the item that is actually being provided as many of the "K" codes do not support the modifications needed for pediatric chairs (K0003 may be on your invoice, when E1220 most accurately describes the chair provided). Pricing may not be altered on your additional documentation as the modifications that are on your invoice and the appropriately reported base code will provide appropriate reimbursement. You should be aware that invoices are informational unless you are submitting a code that does require manual pricing which will be reimbursed from the MSRP on the quote.

*****Quotes should be customized to the patient for whom they are requested, the patient must be identified on the quote submitted by name or customer # (if the customer number is used to link the member which is often seen as a result of HIPAA, then the provider must ensure this is in the members file as it is part of the medical record for purposes of DME reimbursement. A quote number is also required (this will be converted to a purchased invoice once approved) which links the paid quote to the paid invoice (secondary and tertiary discounts may be excluded from the quote). This documentation may be requested by the Division for proof of purchase at any time and the items purchased must match the items on the quote submitted for reimbursement. There are no exceptions. Quotes that are not converted to a purchase by the DME provider are subject to recoupment as there is no receipt of an actual purchase of the equipment that has been reimbursed if this information is not on file.*

Note: The manufacturer from whom the quote is submitted is the manufacturer for which the items must be purchased. If this does not occur any difference in the payment will be recouped. It is the responsibility of the provider to deliver the items as approved.

The pricing methodology for manually priced items that contain all required components (a-c) is 40% above the provider's cost (cost should include the primary discount deduction) **up to the Medicaid maximum allowable amount**. The Department does not reimburse MSRP.

a) MSRP
b) Primary Discount
c) Net Cost
d) HCPCS Code

## 15. Face-To-Face Requirement

Section 6407 of the Affordable Care Act established a face-to-face encounter requirement for certain DME items (Appendix F). The physicians' office must document that a physician, nurse practitioner, physician assistant, or clinical nurse specialist has had a face-to-face encounter with the patient. The face-to-face encounter must occur six months before the order is written for the DME item.

The face-to-face requirement applies to all base equipment and additions, accessories, and modifications exceeding $200.00 and any item requiring a Prior Authorization (purchase/rentals etc.) Accessories requiring prior authorization require a face-to-face before a prior authorization will be extended or renewed.

This section does not apply to Power Mobility Devices (PMDs) as these items are covered under a separate requirement (PMDs in the Part II Manual).

The date of the written order must not be prior to the date of the face-to-face encounter.

The face-to-face encounter conducted by the physician, PA, NP, or CNS must document that the beneficiary was evaluated or treated for a condition that supports the item of DME ordered.

If DME is ordered by a PA, NP, or CNS, a physician (MD or DO) must document the occurrence of a face-to-face encounter by signing or co-signing, and dating, the pertinent portion of the medical record. Georgia Medicaid will accept a single confirming signature, including the date, as sufficient if there are several pertinent portions of the medical record.

## 16. Miscellaneous Documentation Issues

### Repair and Maintenance

Payment may be made for repairs, maintenance, and replacement of medically necessary DME which the beneficiary owns; including equipment used before the beneficiary enrolled in the Medicaid program (unless replacing the item is more cost effective than repairs or maintenance). Payments for repairs or maintenance do not include the payment for parts and labor covered under the manufacturer or supplier's warranty.

Please refer to individual medical policies in the Part II Manual for DME or O&P Services for specific coverage, warranty, and payment provisions.

**Delivery and Service Charges**

Delivery charges are included in the price of the equipment or supplies. Please refer to the SMAP and Part II Manuals for DME or O&P for pricing questions. Do not submit charges for service or delivery of DMEPOS items; charges for service or delivery will be denied.

**Same or Similar Equipment**

Numerous prior authorizations or claims for durable medical equipment shall be denied if the equipment involved is the same as or similar to equipment already in the possession of the beneficiary and has not exceeded the reasonable useful lifetime as stated in the policy manuals. The statutory basis for denial of such claims is Medical Necessity as Backup equipment or duplicate (standby and precautionary), which have no coverage benefit and are not considered medically necessary.

**Pick-up Slips for Same or Similar Equipment**

Georgia Medicaid Policy specifically forbids payments for multiple claims for rental or purchases of same or similar equipment from either the same or for different suppliers during the same rental month, or during the reasonable useful lifetime of the equipment. For purposes of this section, a pick-up slip is written confirmation, provided by a supplier, that the supplier has removed an item of DME from the beneficiary's home.

When making determinations for reimbursement of equipment that appears to be same or similar to equipment already on file, a pickup ticket must be submitted during the prior authorization or appeal process. Georgia Medicaid, Alliant Health Solutions, or Audit Contractors must ascertain not only whether equipment is present in the home, but also must determine which equipment is being used, or is medically necessary for the patient.

**Backup Equipment**

Backup medical equipment is defined as an identical or similar device that is used to meet the same medical need for the beneficiary but is provided for precautionary reasons to deal with an emergency if the primary piece of equipment malfunctions. Medicaid does not pay separately or make an additional payment for backup equipment. However, if equipment is malfunctioning and is under provider warranty, and is within the reasonable useful lifetime, or being repaired, the provider must provide a loaner device during this time.

You must ensure there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment. An acceptable plan would involve input from the beneficiary, and from the treating physician, and considers the severity of the beneficiary's condition and time restraints in providing

emergency support. The provider is responsible for ensuring that the beneficiary's medical needs for the use of the equipment shall be met on an ongoing and continuous basis, and that there is a plan to deal with interruptions of use of the equipment that would be life-threatening to the beneficiary. The plan may be as simple as furnishing backup equipment; however, Georgia Medicaid will not pay separately for or make any additional payment for the backup equipment of items that are indefinite rentals, or in an active rental period, or within the reasonable useful lifetime of the equipment. If backup equipment is billed, it shall be denied as not being reasonable and necessary.

**Miscellaneous HCPCS Codes**

Unusual services or items and certain covered customized items are generally reported to the Georgia Medicaid with miscellaneous HCPCS codes. These miscellaneous HCPCS codes do not have established fee schedule reimbursement rates. Each item or service is processed based on individual consideration. For unusual services or items, the provider must furnish documentation describing the service or item, the manufacturer name, the product name and number, and the suggested retail price with an invoice. If a customized option or accessory is being billed, the statement must clearly describe what was customized. When necessary, consultants' advice will be obtained.

If the description, manufacturer name, product name, product number, and suggested retail price with associated invoice are not provided with the request for Prior Authorization (PA), the PA will be returned or suspended for additional information. If the provider does not respond to the request for additional information, the PA will be denied for missing information, and the provider shall be responsible for resubmitting the requested information through the reconsideration process.

Miscellaneous HCPCS codes that are covered by Georgia Medicaid must be billed with one (1) Unit of Service with the invoice total as the submitted charge. Any code that is billed with a miscellaneous code that, 1) has a designated HCPCS code, or 2) is explicitly non-covered, or 3) was not submitted with a detailed description that matches the item on the invoice will be denied with no exceptions.

Prior Authorizations that are approved based on medical necessity criteria but denied during claims processing for any policy criteria will be denied without exception. Approval of a prior authorization does not guarantee payment. Policy criteria will be applied.

Georgia Medicaid requires the provider to be actively enrolled in the Georgia Medicaid program for the appropriate category of service (DME and O&P) and is eligible to provide the services submitted for approval and shall not submit PAs for items that are non-covered using miscellaneous HCPCS codes, shall not submit PAs for items that have no coverage or are explicitly non-covered. Georgia Medicaid also expects the provider to have checked the eligibility of the beneficiary, and to and have read and understand the policy guidelines. It is not the responsibility of Alliant Health Solutions to review these guidelines, and if a Prior Authorization is approved and it is later found that one of these guidelines has not been met all claims will be denied.

## 17. NCCI (Procedure to Procedure / Medically Unlikely Edits) Billing Guidelines (See Also: Chapter 200 in the Part I Provider Manual) (Rev. 01/14)

**National Correct Coding Initiative (NCCI) - Georgia Medicaid applies the following billing requirements for submitting claims for reimbursement:**

Procedure codes that are denied by NCCI procedure-to-procedure edits are not separately payable by Medicaid as they are included in the payment for the base equipment or most comprehensive procedure/service or are not covered when reported together if they are provided to the same patient on the same date of service. It is against policy for any provider to resubmit claims for denied procedure codes on a different date of service in an attempt to avoid NCCI edits. If this is discovered at any time by the department all items paid on another date of service will be recouped and the provider may be put on prepayment review and/or reported to the Office of Inspector General's Program Integrity Unit.

**Applies to ALL Services:**

Procedure to Procedure Edits (PTP):

1) All items submitted on a prior authorization for reimbursement must be billed on the same date of service they are provided (mail order may be ship date)

2) The date of service that the procedure is rendered/delivered (limited cases shipped) is the date of service on the claim (excludes supplies with grace period).

3) ALL base procedures along with any related services, options, or accessories must be reported with the date of service they are rendered/delivered or ship date for mail order supplies.

   For DME: Replacement parts, accessories, or refill supplies are the only items that may be reported on a date of service that is not the same as the delivery date of the base equipment.

   Alliant Health Solutions does not review NCCI edits during the prior authorization process. Items approved by Alliant Health Solutions on a prior authorization request that fail NCCI edits are not separately payable and are considered to be included in the base equipment. The DME supplier is responsible for reviewing the NCCI files to determine if it is appropriate to request individual payment for items related to base equipment they provide. NCCI edits have been in place for Medicare for several years so suppliers should be reasonably familiar with these edits.

Medically Unlikely Edits (MUE):

1) The NCCI file is set to deny to units in excess of what CMS (Center's for Medicare and Medicaid Services) has set for the highest level of units allowed and considers billing in excess to be medically unlikely.

# APPENDIX H

(Rev. 7/21)

## Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

| | | |
|---|---|---|
| Amerigroup Community Care<br>1-800-454-3730<br>www.amerigroup.com | Peach State Health Plan<br>866-874-0633<br>www.pshpgeorgia.com | CareSource<br>1-855-202-1058<br>www.caresource.com |

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

| Included Populations | Excluded Populations |
|---|---|
| Parent/Caretaker with Children | Aged, Blind and Disabled |
| Transitional Medicaid | Nursing home |
| Pregnant Women (Right from the Start Medicaid – RSM) | Long-term care (Waivers, SOURCE) |
| Children (Right from the Start Medicaid – RSM) | Federally Recognized Indian Tribe |
| Children (newborn) | Georgia Pediatric Program (GAPP) |

| | |
|---|---|
| Women Eligible Due to Breast and Cervical Cancer | Hospice |
| PeachCare for Kids® | Children's Medical Services program |
| Parent/Caretaker with Children | Medicare Eligible |
| Children under 19 | Supplemental Security Income (SSI) Medicaid |
| Women's Health Medicaid (WHM) | Medically Needy |
| Refugees | Recipients enrolled under group health plans |
| Planning for Healthy Babies® | Individuals enrolled in a Community Based Alternatives for Youths (CBAY) |
| Resource Mothers Outreach | |

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

**Included Categories of Eligibility (COE):**

| COE | DESCRIPTION |
|---|---|
| 104 | LIM – Adult |
| 105 | LIM – Child |
| 118 | LIM – 1st Yr Trans Med Ast Adult |
| 119 | LIM – 1st Yr Trans Med Ast Child |
| 122 | CS Adult 4 Month Extended |

| | |
|---|---|
| 123 | CS Child 4 Month Extended |
| 135 | Newborn Child |
| 170 | RSM Pregnant Women |
| 171 | RSM Child |
| 180 | P4HB Inter Pregnancy Care |
| 181 | P4HB Family Planning Only |
| 182 | P4HB ROMC - LIM |
| 183 | P4HB ROMC - ABD |
| 194 | RSM Expansion Pregnant Women |
| 195 | RSM Expansion Child < 1 Yr |
| 196 | RSM Expn Child w/DOB < = 10/1/83 |
| 197 | RSM Preg Women Income < 185 FPL |
| 245 | Women's Health Medicaid |
| 471 | RSM Child |
| 506 | Refugee (DMP) – Adult |
| 507 | Refugee (DMP) – Child |
| 508 | Post Ref Extended Med – Adult |
| 509 | Post Ref Extended Med – Child |
| 510 | Refugee MAO – Adult |
| 511 | Refugee MAO – Child |
| 571 | Refugee RSM - Child |
| 595 | Refugee RSM Exp. Child < 1 |
| 596 | Refugee RSM Exp Child DOB </= 10/01/83 |
| 790 | Peachcare < 150% FPL |
| 791 | Peachcare 150 – 200% FPL |
| 792 | Peachcare 201 – 235% FPL |
| 793 | Peachcare > 235% FPL |
| 835 | Newborn |
| 836 | Newborn (DFACS) |
| 871 | RSM (DHACS) |
| 876 | RSM Pregnant Women (DHACS) |
| 894 | RSM Exp Pregnant Women (DHACS) |
| 895 | RSM Exp Child < 1 (DHACS) |
| 897 | RSM Pregnant Women Income > 185% FPL (DHACS) |
| 898 | RSM Child < 1 Mother has Aid = 897 (DHACS) |
| 918 | LIM Adult |
| 919 | LIM Child |
| 920 | Refugee Adult |
| 921 | Refugee Child |

**Excluded Categories of Eligibility (COE):**

| COE | DESCRIPTION |
|---|---|
| 124 | Standard Filing Unit – Adult |
| 125 | Standard Filing Unit – Child |
| 131 | Child Welfare Foster Care |
| 132 | State Funded Adoption Assistance |

| | |
|---|---|
| 147 | Family Medically Needy Spend down |
| 148 | Pregnant Women Medical Needy Spend down |
| 172 | RSM 150% Expansion |
| 180 | Interconceptional Waiver |
| 210 | Nursing Home – Aged |
| 211 | Nursing Home – Blind |
| 212 | Nursing Home – Disabled |
| 215 | 30 Day Hospital – Aged |
| 216 | 30 Day Hospital – Blind |
| 217 | 30 Day Hospital – Disabled |
| 218 | Protected Med/1972 Cola - Aged |
| 219 | Protected Med/1972 Cola – Blind |
| 220 | Protected Med/1972 Cola - Disabled |
| 221 | Disabled Widower 1984 Cola - Aged |
| 222 | Disabled Widower 1984 Cola – Blind |
| 223 | Disabled Widower 1984 Cola – Disabled |
| 224 | Pickle - Aged |
| 225 | Pickle – Blind |
| 226 | Pickle – Disabled |
| 227 | Disabled Adult Child - Aged |
| 227 | Disabled Adult Child - Aged |
| 229 | Disabled Adult Child – Disabled |
| 230 | Disabled Widower Age 50-59 – Aged |
| 231 | Disabled Widower Age 50-59 – Blind |
| 232 | Disabled Widower Age 50-59 – Disabled |
| 233 | Widower Age 60-64 – Aged |
| 234 | Widower Age 60-64 – Blind |
| 235 | Widower Age 60-64 – Disabled |
| 236 | 3 Mo. Prior Medicaid – Aged |
| 237 | 3 Mo. Prior Medicaid – Blind |
| 238 | 3 Mo. Prior Medicaid – Disabled |
| 239 | Abd Med. Needy Defacto – Aged |
| 240 | Abd Med. Needy Defacto – Blind |
| 241 | Abd Med. Needy Defacto – Disabled |
| 242 | Abd Med Spend down – Aged |
| 243 | Abd Med Spend down – Blind |
| 244 | Abd Med Spend down – Disabled |
| 246 | Ticket to Work |
| 247 | Disabled Child – 1996 |
| 250 | Deeming Waiver |
| 251 | Independent Waiver |
| 252 | Mental Retardation Waiver |
| 253 | Laurens Co. Waiver |
| 254 | HIV Waiver |
| 255 | Cystic Fibrosis Waiver |
| 259 | Community Care Waiver |

| | |
|---|---|
| 280 | Hospice – Aged |
| 281 | Hospice – Blind |
| 282 | Hospice – Disabled |
| 283 | LTC Med. Needy Defacto – Aged |
| 284 | LTC Med. Needy Defacto –Blind |
| 285 | LTC Med. Needy Defacto – Disabled |
| 286 | LTC Med. Needy Spend down – Aged |
| 287 | LTC Med. Needy Spend down – Blind |
| 288 | LTC Med. Needy Spend down – Disabled |
| 289 | Institutional Hospice – Aged |
| 290 | Institutional Hospice – Blind |
| 291 | Institutional Hospice – Disabled |
| 301 | SSI – Aged |
| 302 | SSI – Blind |
| 303 | SSI – Disabled |
| 304 | SSI Appeal – Aged |
| 305 | SSI Appeal – Blind |
| 306 | SSI Appeal – Disabled |
| 307 | SSI Work Continuance – Aged |
| 309 | SSI Work Continuance – Disabled |
| 308 | SSI Work Continuance – Blind |
| 315 | SSI Zebley Child |
| 321 | SSI E02 Month – Aged |
| 322 | SSI E02 Month – Blind |
| 323 | SSI E02 Month – Disabled |
| 387 | SSI Trans. Medicaid – Aged |
| 388 | SSI Trans. Medicaid – Blind |
| 389 | SSI Trans. Medicaid – Disabled |
| 410 | Nursing Home – Aged |
| 411 | Nursing Home – Blind |
| 412 | Nursing Home – Disabled |
| 424 | Pickle – Aged |
| 425 | Pickle – Blind |
| 426 | Pickle – Disabled |
| 427 | Disabled Adult Child – Aged |
| 428 | Disabled Adult Child – Blind |
| 429 | Disabled Adult Child – Disabled |
| 445 | N07 Child |
| 446 | Widower – Aged |
| 447 | Widower – Blind |
| 448 | Widower – Disabled |
| 460 | Qualified Medicare Beneficiary |
| 466 | Spec. Low Inc. Medicare Beneficiary |
| 575 | Refugee Med. Needy Spend down |
| 660 | Qualified Medicare Beneficiary |
| 661 | Spec. Low Income Medicare Beneficiary |

| | |
|---|---|
| 662 | Q11 Beneficiary |
| 663 | Q12 Beneficiary |
| 664 | Qua. Working Disabled Individual |
| 815 | Aged Inmate |
| 817 | Disabled Inmate |
| 870 | Emergency Alien – Adult |
| 873 | Emergency Alien – Child |
| 874 | Pregnant Adult Inmate |
| 915 | Aged MAO |
| 916 | Blind MAO |
| 917 | Disabled MAO |
| 983 | Aged Medically Needy |
| 984 | Blind Medically Needy |
| 985 | Disabled Medically Needy |

## HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 800-454-3730<br>(general information)<br>www.amerigroup.com | 1-855-202-1058<br>www.careSource.com/GeorgiaMedicaid | 866-874-0633 (general information)<br>866-874-0633 (claims)<br>800-704-1483 (medical management)<br>www.pshpgeorgia.com |

### Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

### Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

**Use of the Medicaid Management Information System (MMIS) web portal:**

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

**Participating in a Georgia Families' health plan:**

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

**Billing the health plans for services provided:**

For members who are in Georgia Families, you should file claims with the member's health plan.

**If a claim is submitted to GAINWELL TECHNOLOGIES in error:**

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

**Credentialing**

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services are provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45

calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

**Assignment of separate provider numbers by all of the health plans:**

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

**Billing the health plans for services provided:**

For members who are in Georgia Families, you should file claims with the member's health plan.

**If a claim is submitted to GAINWELL TECHNOLOGIES in error:**

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

**Receiving payment:**

Claims should be submitted to the member's health plan. Each health plan has its own claims processing, and you should consult the health plan about their payment procedures.

**Health plans payment of clean claims:**

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| Amerigroup runs claims cycles twice each week (on Monday and Thursday) for clean claims that have been adjudicated.<br><br>Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday.<br><br>Thursday Claims run: Checks mailed on Wednesday. Providers | CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated.<br><br>Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays. | Peach State has two weekly claims payment cycles per week that produces payments for clean claims to providers on Monday and Wednesday.<br><br>For further information, please refer to the Peach State website, or the Peach State provider manual. |

| | | |
|---|---|---|
| enrolled in ERA/EFT receive the ACH on Tuesday.<br>Dental: Checks are mailed weekly on Thursday for clean claims.<br>Vision: Checks are mailed weekly on Wednesday for clean claims (beginning June 7th)<br>Pharmacy: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day) | | |

**How often can a patient change his/her PCP?**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| Anytime | Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as:<br>• Member requests to be assigned to a family member's PCP<br>• PCP does not provide the covered services a member seeks due to moral or religious objections<br>• PCP moves, retires, etc. | Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change. |

**Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| | | |

| | | |
|---|---|---|
| Next business day | PCP selections are updated in CareSource's systems daily. | PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month. |

**PHARMACY**

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx | 844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod | 866-874-0633 www.pshpgeorgia.com |

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

**The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:**

| Health Plan | PBM | BIN # | PCN # | GROUP # | Helpdesk |
|---|---|---|---|---|---|
| Amerigroup Community Care | IngenioRx | 020107 | HL | WKJA | 1-833-235-2031 |
| CareSource | Express Scripts (ESI) | 003858 | MA | RXINN01 | 1-800-416-3630 |
| Peach State Health Plan | CVS | 004336 | MCAIDADV | RX5439 | 1-844-297-0513 |

**If a patient does not have an identification card:**

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| No, you will need the member's health plan ID number | Yes, you may also use the health plan ID number. | Yes |

**Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:**

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

**Will Medicaid cover prescriptions for members that the health plans do not?**

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

**Who to call to request a PA:**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 1 (800) 454-3730 | 1 (855) 202-1058<br>1 (866) 930-0019 (fax) | 1 (866) 399-0929 |

# APPENDIX I

## GEORGIA 360°

***Information for Providers Serving Medicaid Members***
**In the Georgia Families 360$^{0}$ SM Program**

**Georgia Families 360$^{0}$ SM**, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360$^{0}$SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

**Georgia Families 360$^{0}$ SM** Every member in Georgia Families 360$^{0}$ is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members will also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements.

Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

**Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.**

**To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.**

# APPENDIX J

## GENERAL CLAIMS SUBMISSION POLICY FOR ORDERING, PRESCRIBING, REFERRING (OPR) PROVIDERS

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe, and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing, and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

**For the NEW CMS-1500 claim form:**
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

**For claims entered via the web:**
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

**For claims transmitted via EDI:**
The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

# APPENDIX K

(Rev. 07/22)

## GEORGIA HEALTH PARTNERSHIP (GHP)

**Provider Inquiries:**

1-800-766-4456 (Toll Free)

Web Address: www.mmis.georgia.gov

**Provider Correspondence:**

Gainwell Technologies

P.O. Box 105200
Tucker, Georgia 30085-5201

**Provider Enrollment:**

Gainwell Technologies

P.O. Box 105200
Tucker, Georgia 30085-5201

**Electronic Data Interchange (EDI)**

1-800-267-8785

- Asynchronous
- Web Portal
- Physical Media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/Internet Protocol (TCP/IP)

**Prior Authorization Requests:**

Alliant Health Solutions

Web Portal: www.mmis.georgia.gov
1-800-766-4456 (Toll Free)

**Member Services:**

1-866-211-0950

#1 for Eligibility, Service Limits, Copays
#2 Georgia Families
#3 Requests for New ID Card
#4 Changes to Primary Care Physician
#5 Questions IRS-1095 Form
#6 All Other (Including Pharmacy Benefit)

*or visit the following web address:*

www.mmis.georgia.gov and select Member Information

# APPENDIX L

## INTENTIONALLY LEFT BLANK

# APPENDIX M

## COMMONLY ASKED QUESTIONS

1) **How do I bill repairs/labor with K0739 U1 and U2?**
   The labor component for repairs is coded K0739 U1 (Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component). K0739 U2 is reported in conjunction with K0739 U1 when repairs are for custom or specialty parts that do not have a HCPCS code. If modifier U2 is used to report custom repairs/parts, then an itemized list must be submitted, and the total price must be the submitted charge.

2) **How do I submit miscellaneous codes such as L9900 or K0108 on the Prior Authorization?**
   These codes are to be submitted ONE time with ONE unit of service with the invoice for the items that are to be included in this code. The total price for ALL items to be included as miscellaneous/additions etc. are submitted for the price to be approved for the code. Requesting multiple Prior Authorizations for more than 1 unit of service for a miscellaneous code or more than one-line item or unit of service for these types of codes will be denied as incorrect billing.

3) **What information should be submitted with a Prior Authorization?**
   All supporting documentation must be submitted as attachments with the prior authorization requests for a decision to be made for reimbursement. Failure to provide required necessary documentation (Detailed written order, CMN, additional supporting documentation when required by policy) or documentation that does not contain the information required to support the medical necessity (length of need, height/weight, etc.) of the items requested will result in a request for this information and will extend the time it takes to complete the request. Failure to comply with requests for additional supporting documentation will result in a denial of the prior authorization request.

4) **The DMA-610 (Prior Authorization Request Form) listed in the manual has "SAMPLE" written across it, where can I find a clean copy to use for faxing Prior Authorization requests?**
   The form in the manual is an example of the form you will find on MMIS under the "Forms" link. You will find all PA forms located here as well as providers manuals etc. Please familiarize yourself with the location of this form online as links are subject to change.

   **Refer to:** www.mmis.georgia.gov → Provider Information → Forms for Providers → PG. 2, DMA-610: Prior Authorization Request

5) **When does the "Single Entry for PA's go-live for DME with Alliant Health Solutions Prior Authorization Portal?**
   For CMO's this will be in Phase II of the Centralized PA/Pre-Cert Portal -Single Point of Entry Project. It has a proposed schedule for DME in early to mid-2014. For regular FFS this is already a current functionality in MMIS.

6) **Does Georgia Medicaid provide wound coverage for members over twenty-one (21) years of age?**
Wound Devices are limited to 21 and under, however, wound care supplies are a separate policy which is not restricted by age. This policy was implemented during the July 2013 updates.

7) **Is the Apnea Monitor changing to a capped rental? We are concerned that the cost of frequently servicing the item (making home trips, etc.) for alarms resets and other issues will become unaffordable if the item is set to cap.**
Apnea monitors are covered primarily for premature infants. This item is expected to be used for 2-3 months unless there are special circumstances requiring up to 6 months of use (this should be rare). The item will not be set to a capped rental but is not expected to be used for an extended period of time.

8) **It is very difficult to get the physical therapist to attend the PMD delivery due to scheduling issues. Why is this required?**
This is no longer required for PMDs delivered on or after 01/01/2014. For PMDs delivered on or before 12/31/2013 this assessment must be in the medical record.

9) **Many providers are now using electronic signatures to authenticate orders and CMNs, is this acceptable?**
Yes, the physician can sign using either handwritten or electronic signatures and dates. No, they cannot use any type of signature or date stamps which are not authenticated by personalized and protected user IDs/Passwords.

10) **What is the appropriate usage of HCPCS code E1028?**
Georgia Medicaid follows CMS Guidelines for the use of E1028. The MUE file limits this code to 4 units which may apply to the following:

    1) Swing away hardware used with remote joysticks or touchpads.
    2) Swing away or flip-down hardware for head control interfaces (E2327-E2330), and
    3) Swing away hardware for an indicator display box that is related to the multi-motor electronic connection codes (E2310 or E2311).

    Code E1028 is not to be used for swing away hardware used with a sip and puff interface (E2325) because swing away hardware is included in the allowance for that code. Code E1028 is not to be used for hardware on a wheelchair tray (E0950). Do not use E1028 in addition to E1020 (Residual limb support system) as it includes swing away hardware.

11) **Can a claim be dually coded with ICD-9-CM AND ICD-10-CM codes prior to the effective date of 10/01/2015 for required use of ICD-10-CM?**
No, you must submit the ICD-9-CM codes on or before 09/30/2015 or ICD-10-CM codes on or after 10/01/2015**.**

12) **Does a patient need to visit their physician in order to receive an ICD-10-CM code?**
No. Please do not instruct patients to visit their doctor for ICD-10-CM codes! The diagnosis is not changing, and the physician would not be reimbursed for such a visit,

nor would they provide you with ICD-10-CM codes. Your billing staff must be prepared to code from ICD-9-CM to ICD-10-CM. There are many tools available to assist you with mapping codes. You should be aware that not all codes have a map to code, and it will be the billing staff who must be trained to code your claims. If you need additional information to be able to select the most specific or appropriate code, then you may want to reach out to the healthcare provider.

13) **Do I need to update a Prior Authorization with ICD-10-CM codes if the PA was approved before 10/01/2015 for items that have an extended approval period that spans the mandate timeframe for ICD-9 and ICD-10? Capped rental items are a good example of when you may see dates span before and after implementation of ICD-10.**
No, you do not need to update an approved PA. The CLAIM must have the appropriate codes as determined by the date of service, but the PA will pay the approved units/dollars without modification. For a PA that is submitted after 10/01/2015 you must request approval with the appropriate ICD-10-CM codes

14) **Where can providers find additional information about ICD-10?**
Additional information to help with your ICD-10 planning and preparation is available on the following websites.

- **Centers for Medicare & Medicaid Services (CMS) ICD-10 site**
http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10
- **Medicare Learning Network** http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/
- **Workgroup for Electronic Data Interchange (WEDI)**
http://www.wedi.org/workgroups/icd-10
- **American Health Information Management Association (AHIMA)**
http://www.ahima.org/
- **American Hospital Association (AHA)**
http://www.aha.com
- **American Academy of Professional Coders (AAPC)**
http://www.aapc.com/icd-10/index.aspx

# APPENDIX N

## INTENTIONALLY LEFT BLANK

# APPENDIX O

## COMMON MODIFIERS

**NU – New Durable Medical Equipment Purchase**

**This modifier is used for new DME items that are purchased. When using the NU modifier, you are indicating you have furnished the beneficiary with a new (never used) piece of equipment.**

**RR – Rental Durable Medical Equipment**

**This modifier is used for DME items that are rented.**

**U1, U2, U3 – Medicaid Level of Care 1, As Defined by Each State**

**This modifier is used for DME items that may require manual pricing, and to allow overutilization on the max units of select procedure codes as indicated on the Schedule of Maximum Allowable Payment (SMAP).**